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Mental Health in Northern Alberta: Addressing the Issues

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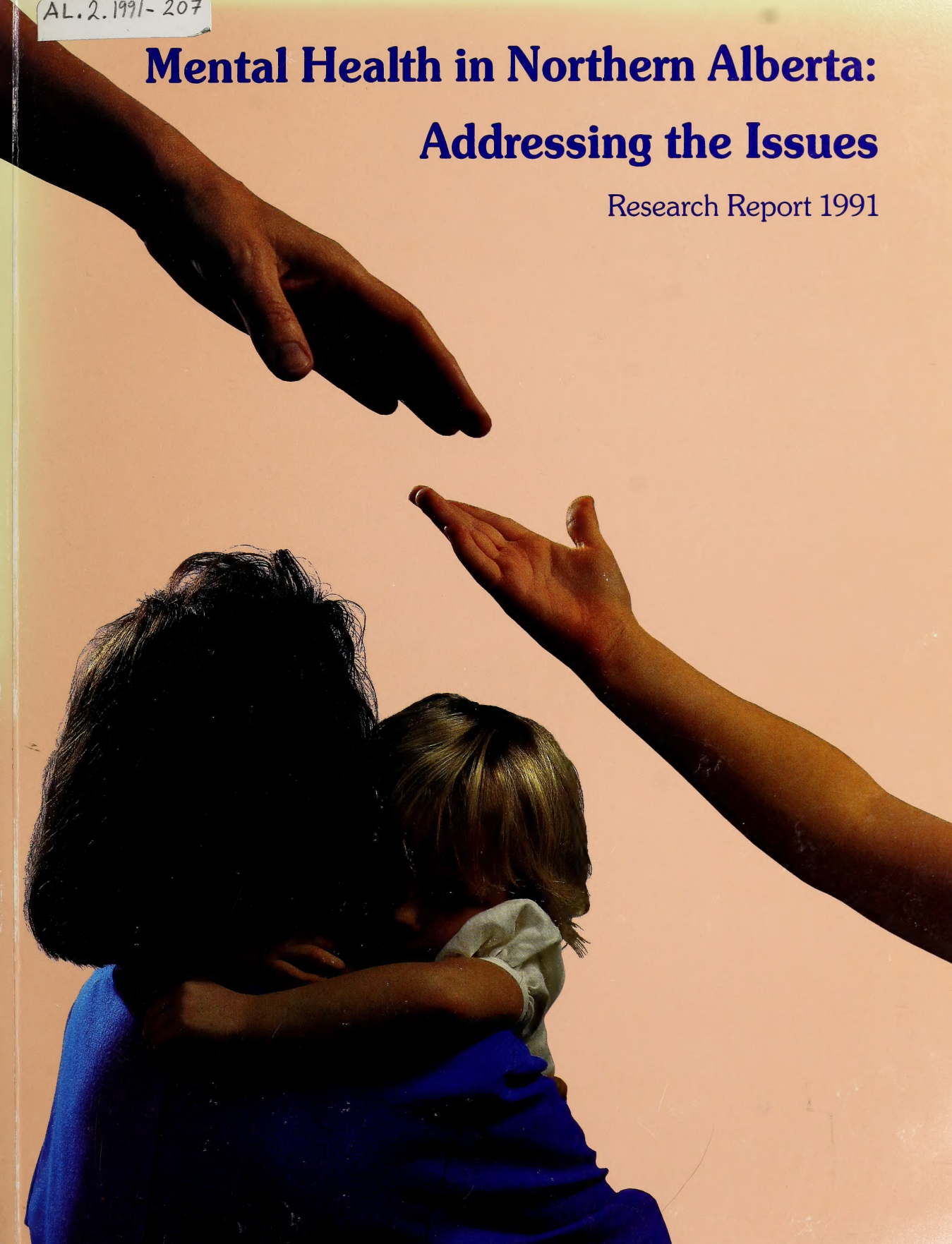

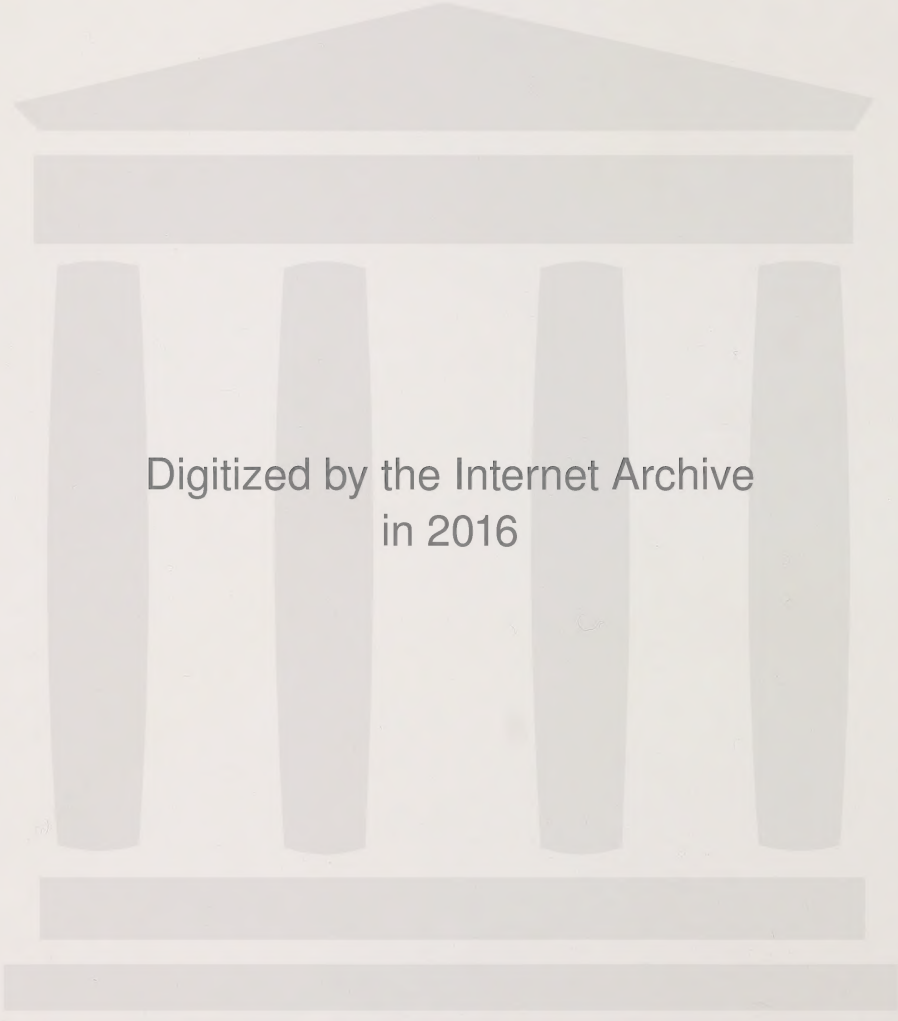

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Mental Health in Northern Alberta: Addressing the Issues

Research Report

Prepared by
The Alberta Management Group
Edmonton, Alberta

Prepared for
The Northern Alberta Development Council
Peace River, Alberta

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The Alberta Management Group is indebted to Northern Development staff and the Steering Committee assigned to this project for their patience, continuing support, and valuable guidance.

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TDW
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Executive Summary

The Northern Alberta Development Council (NADC) is mandated to advocate on behalf of northern residents on issues relating to social and economic development and government services. In response to mounting concerns expressed by many northern communities regarding mental health services, the NADC, in cooperation with Alberta Health, commissioned a comprehensive study to identify strategies to improve the quality and quantity of mental health services in northern Alberta.

The objectives of the study were:

1. To review existing mental health services and outline service gaps
2. To examine service impediments experienced in northern Alberta, including: recruitment, staff retention, sparse population, distance, and special needs groups; and to explore ways to overcome them
3. To examine existing and proposed coordination activities and innovative projects
4. To recommend ways to:
   a) improve existing services and identify needed new services that will reduce existing gaps
   b) reduce service delivery impediments
   c) reduce the effects of service delivery impediments through alternative methods of service delivery
   d) improve service coordination activities
5. To propose a series of strategies for implementing the recommendations.

The scope of the project is broad, including mental health-related services provided by Alberta Mental Health, AADAC, FCSS agencies, Child Welfare, health units, hospitals, and others.

Data gathering procedures were conducted in progressive stages, with each stage contributing to the next. These included:

- A review of 58 briefs and reports relating to mental health issues in northern Alberta, along with a review of four northern innovative projects designed to facilitate coordination and cooperation among service providers and agencies, and a review of innovative strategies from the literature
- Visits to 10 northern Alberta communities to obtain the views of service providers and planners, service users, and the public at large
- A survey of northern Alberta service providers representing 42 different communities and community clusters to clarify and expand on the information obtained from our reviews and community visits.

Three principal conclusions emerged from the data gathering phase:

1. Current service delivery systems fall short of meeting the mental health needs of many northern residents.
2. Service deficiencies are most severe for northern Albertans living in towns and smaller communities outside Fort McMurray and Grande Prairie and, to a lesser extent, outside the service centres of Peace River and St. Paul — with deficiencies being more pronounced as community size decreases and remoteness increases.
3. Service delivery issues vary considerably from community to community.

A consistent set of issues arose regarding weaknesses in the current system which impede residents from receiving the services they require. Major impediments included:

- *Lack of Resources* — staff shortages caused by insufficient funding, recruitment and retention difficulties, and system inefficiencies
- *Lack of Coordination* — difficulties in the coordination of services among local agencies and between local and external service providers caused by mandate restrictions and lack of time to plan and implement coordination initiatives
- *Insufficient Worker Skills* — a condition caused in large part by crises backing up into the caseloads of local service providers (particularly those working with community-based agencies) who have not been trained to deal effectively with them, insufficient preparation for northern practice experienced by some professionals, and the lack of funds to hire experienced staff qualified to deal with the caseloads being encountered

- *Lack of Community Control* — insufficient community control over problem definition, program planning, and resource allocation decisions caused by the lack of effective mechanisms for meaningful community input, and a perceived lack of respect on the part of central authorities for the ability and capacity of communities to assume greater responsibility and accountability for service provision
- *Lack of Community Involvement and Organization* — overreliance on external services and service providers due to limitations in community resources needed to develop and expand community-based services.

The above issues are manifested differently in each community, suggesting that a flexible and multi-faceted strategy is required to meet the needs of northern residents for mental health services.

Following data collection, workshops were held in St. Paul and Peace River with northern service planners and providers to consolidate our findings, prioritize issues, identify key principles and values for guiding mental health service delivery in northern Alberta, and to develop strategies and solutions for addressing the issues.

The image that emerged was of a system under great pressure. Workers are increasingly preoccupied with crises and have neither the time nor the authority to initiate necessary changes to the system.

At the same time, communities appear to be moving toward greater self-sufficiency and less dependence on outside resources. Local service capacity exists in most communities, but is being under-utilized. Communities desire mechanisms to cultivate and better utilize these resources in ways which reflect local culture, values, needs and priorities.

Two key principles and values for guiding mental health service delivery in northern Alberta were developed:

- ***Prominence of Local Service Providers* — to the greatest extent possible, services should be provided in the community by residents of the community. Local service providers must be identified, developed, activated, and supported as the initial and primary givers of care to community residents, with external professionals/specialists serving in a developmental and support role as educators and consultants.**
- ***Local Input and Control* — to the greatest extent possible, decisions regarding needs, priorities, services, and resource allocation should be made at the community level. Mechanisms must be implemented which provide for grass-roots input, and for delegation of responsibility, authority, and accountability to the community.**

Adherence to these principles was seen to have the following impact on the issues that were identified during the course of this study, and which have been categorized as community, agency, worker, and client impediments to optimal mental health service delivery in northern Alberta:

Community Impediments

- *Lack of Control* — Delegation of greater decision-making authority to the community regarding service delivery will fundamentally alter governance and power, and result in greater community control.
- *Lack of Involvement* — Using external resources to develop and support local resources is a major human resource and service development initiative. Delegation of authority further enhances community involvement by shifting responsibility and accountability to the community level, fostering the emergence of community activism and leadership.

Agency Impediments

- *Lack of Resources* — Changing the role of professionals practising in the north will enhance the attractiveness of northern practice and mitigate recruitment and retention problems. Using more local resources also greatly diminishes recruitment and retention issues, and will generate resource efficiencies by reducing the proportion of professional travel and salary costs in direct service delivery (e.g., therapy). Greater community control will foster improvements in coordination and collaboration, further enhancing resource efficiencies. Community-based boards will also provide a stronger and more coherent funding lobby on behalf of special needs groups.
- *Lack of Coordination* — Changes to the rela-

tionship between professionals and paraprofessionals will foster improved teamwork. Closer coordination and cooperation at the agency level will be fostered with stronger monitoring and advocacy responsibility and authority at the community level.

Worker Impediments

- *Lack of Skills* — Community resources will be better prepared to handle the caseloads they face with access to education and consultation from professionals working as part of the service delivery team.
- *Role Restrictions* — The community will have greater influence over agency policies that govern the roles played by service providers, freeing workers from conflicts in performing the function needed in the community. Establishing a new working relationship between external professionals and local service providers will also help to break down traditional stereotyping that restricts service providers from considering alternative roles.

Client Impediments

- *Excessive Travel/Cost* — Use of local resources as primary service providers will greatly reduce the need for residents to travel to receive service.
- *Lack of Awareness* — Greater community control and the engagement of more local residents as service providers (formal and informal) will enhance community awareness of available services.
- *Stigma* — Enhancement of the indigenous service capacity within the community will generally increase the exposure of residents to mental health issues framed and discussed in a relevant local context.
- *Lack of Trust* — Residents are perceived generally to have greater comfort with services designed locally and provided by local resources.

The following recommendations were made, based on our understanding of the direction northerners have chosen for the governance and delivery of mental health services in northern Alberta:

1. **We recommend that the province establish appropriate mechanisms and the necessary resources to enable communities to employ local personnel to provide a wide range of community-based mental health services.**
2. **We recommend that the province promote the establishment of regional mental health boards that will enhance northern communities' input to and control over decisions regarding needs, priorities, services, standards and the allocation of mental health resources in northern Alberta.**
3. **We recommend that Alberta Health (Mental Health Division) and the Public Service Commission take immediate steps to fill professional mental health positions in northern Alberta, and to develop a long-term recruitment and retention strategy for filling vacancies quickly and reducing staff turnover.**
4. **We recommend that the province reallocate funding to provide better support for community-based mental health services in the north.**
5. **We recommend that the province, in consultation with consumers and providers of mental health services, define basic mental health services that all northern Albertans have the right to access, regardless of where they reside in the north.**
6. **We recommend that the province selectively insure private psychological and social work services under the Alberta Health Care Insurance Plan for residents of rural northern Alberta communities on a trial basis with an appropriate evaluation.**
7. **We recommend that the province initiate a comprehensive campaign to increase awareness of mental health services, and to reduce attitudinal barriers among northern residents.**
8. **We recommend that the province allocate more resources to mental wellness and to mental health promotion and education initiatives.**

Specific actions for implementing the recommendations are included.

Mental Health in Northern Alberta: Addressing the Issues

Research Report

January, 1991

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Part I
Introduction

Purpose, Scope and Methodology

This study has been commissioned by the Northern Alberta Development Council in response to growing concerns about the delivery of mental health services in northern Alberta. The purpose of the study is to identify service delivery issues in the north; to recommend ways to improve service delivery consistent with the needs, aspirations, and environments of northern residents; and to heighten public and government awareness of mental health service delivery issues in the north.

The objectives of the study are:

1. To review existing mental health services and outline service gaps
2. To examine service impediments experienced in northern Alberta, including: recruitment, staff retention, sparse population, distance, and special needs groups; and to explore ways to overcome them
3. To examine existing and proposed coordination activities and innovative projects
4. To recommend ways to:
   a) improve existing services and identify needed new services that will reduce existing gaps
   b) reduce service delivery impediments
   c) reduce the effects of service delivery impediments through alternative methods of service delivery
   d) improve service coordination activities
5. To propose a series of strategies for implementing the recommendations.

The following services are included in the scope of this project:

Treatment Services:
- family violence
- life skills
- school counselling
- alcohol and drug abuse counselling
- rehabilitation and vocational services
- community corrections

Hospital Services:
- in-patient services
- out-patient services
- emergency services
- designation

Mental Illness Prevention Services:
- home care
- public health nursing

Assessment and Referral Services

Pastoral Care

Bereavement Services

Family Services

Suicide Prevention

Crisis Intervention Services:
- family violence
- school counselling
- RCMP

Private Practitioners

Mental Health Promotion Activities and Services

Cross-Cultural Services:
- native counselling
- traditional caring
- friendship centres

This study was conducted in two phases. The first, or data gathering phase, included the following activities:

- a review of northern and provincial reports relating to mental health service delivery issues in the north, and recent innovative projects designed to facilitate service coordination and cooperation
- visits to 10 northern communities to obtain and discuss, first hand, the views of service providers and planners, service users, and the public at large
- a survey of mental health service providers in the north to confirm, clarify, and expand on the information obtained from our reviews and community visits.

Findings from this phase are presented in the section entitled *Part II: Identifying the Issues.*

In the second phase, workshops were held in St. Paul and Peace River with service planners and providers from all across northern Alberta. The purpose was to: consolidate our findings; prioritize issues; identify key principles and values for guiding mental health service delivery in northern Alberta; and develop strategies and solutions for addressing the issues. The results of these workshops and our recommendations are presented in the section entitled *Part III: Addressing the Issues.*

Terms of reference for this project were prepared by an 11-member steering committee that was also responsible for overseeing and guiding its progress. Steering committee members are as follows:

- Ms Phyllis Beairsto, Member-At-Large, Grande Prairie
- Ms Hildegard Campsall, Chief Executive Officer, Peace River Health Unit, Peace River
- Ms Jeanne Cardinal, Administrator/Program Coordinator Peekiskwetan-Let's Talk Agency, Wabasca-Desmarais
- Dr. Ronald Dyck, Provincial Suicidologist, Edmonton
- Ms Jacquie Gaboury, Executive Director, PACE Crisis Line, Grande Prairie
- Ms Elaine Gauthier, Member, Northern Alberta Development Council, Plamondon
- Mr. Mel Kuprowsky, Regional Planner/Regional Communications Manager, Northeast Region, Alberta Family & Social Services, Lac La Biche
- Ms Carol Molstad, Northeast Regional Director, Alberta Mental Health, Fort McMurray
- Mr. David Moncrieff, Northwest Regional Director, Alberta Mental Health, Grande Prairie
- Mr. Brian Pountney (Project Manager), Senior Northern Development Officer, Northern Development Branch, Peace River
- Mr. Alan H. Taylor, Executive Director, Athabasca Family & Community Support Services, Athabasca.

Preliminary Discussion

Three crucial concepts which underlie this task need to be discussed and clarified at the outset: *mental health, north*, and *services*. A dynamic broad definition of *mental health* is necessary to allow for identification and exploration of resources, limitations, and issues in a variety of community settings. The *north* also has to be defined as a unique setting for human activity. Otherwise, there is the danger of imposing southern assumptions and conventional methodology on the region, and of missing the opportunity to focus on "special" northern features. A broad concept of *service* is also required to ensure that local systems of support and caring, and the context in which these occur, are recognized.

This preliminary discussion is purposely broad in scope. Issues specific to mental health services in northern Alberta are the focus of *Part II: Identifying the Issues.*

Mental Health

Fortunately, much recent work has been done on the development of a useful definition of mental health. Health & Welfare Canada recognized the importance of a comprehensive definition as a prerequisite to any articulation of problems, ranking of issues, or determination of service goals and strategies. Their 1988 report *Mental Health for Canadians: Striking A Balance* reveals a deliberate attempt to move past the traditional pathology-oriented definitions where mental health was simply the absence of psychiatric symptoms. Health & Welfare Canada promotes a view of mental health as a resource allowing people to influence their environment, individually and collectively. They developed the following interactive definition:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality . . . In the new definition, individual strengths, collective energies, and environmental resources interact to produce mental health (p. 7).

This definition places clear emphasis on interaction between persons and their environments. Mental health here is more than just a cognitive state or individual trait. A person does not achieve mental health in isolation but rather develops it as a resource through interaction with other persons, groups, and the larger community. From this perspective, supportive and challenging communities are as crucial to mental health as are individual coping abilities.

Obstacles to mental health can then be seen as disruptions or harmful imbalances in the interactive fit between persons and environments. These may involve features of the individual (such as physical illness, mental disorder, poverty, poor coping skills), the group (such as family tension, employment stress), or the larger environment (harsh physical conditions, social injustice, limited economic opportunities, inequality).

The literature offers many categories for understanding individual and group factors bearing upon mental health. Far less attention has been paid to influences from the larger environment.

North

As a general rule, the major models of professional helping are developed and taught in urban centres. Students training to become professional mental health practitioners usually learn these models in urban university or college settings, reinforced by field placements in urban agency settings. Most social science disciplines have developed a specialization for consideration of issues outside of urban areas (for example: rural sociology, rural psychology, rural social work). The problem is that nearly all of our rural theory comes from the United States, and these specializations therefore tend to rely upon an American view of rurality. Rural communities are presented as small settlements (less than 10,000 population) with an economy based on primary production (usually agriculture) and special service needs related to distance and small population. The

thrust of the rural practice literature has been how to adapt urban programs and services for non-urban areas, how to overcome geographic obstacles and community resistance to ensure that rural people have access to the services available in the city. This approach in effect views rural people as "disadvantaged urbanites". Similar goals and aspirations are assumed; only practice techniques and delivery strategies require adaptation.

Perhaps this approach to rural practice is appropriate for some agricultural areas within range of large cities, but it does not go far enough for practice in northern Canada where the world views and goals may differ significantly from the urban south. In other words, northern Canada is NOT just another rural area, especially when assessed by the criteria of the American view of rurality offered in the rural practice literature.

Attempting to apply the rural characteristic of low population density to northern Canada leaves one in awe of the immensity of the region. This country has been described as an enormous hinterland resting above a narrow southern ribbon of population. It has been estimated that nine out of 10 Canadians live within 300 kilometres of the American border (six out of 10 in the narrow urban corridor between Quebec City and Windsor). In contrast, Canada's north has been depicted as "the presence of only about 250 small communities scattered across a territory as large as Europe," reflecting the reality that one percent of our population occupies the northern 80 percent of our land mass. Surely this vast wilderness area stretches the American rural characteristic of low population density beyond relevance.

The rural practice literature also observes that advances in transportation are reducing the isolation in modern rural communities, yet this pattern does not generalize easily to the Canadian north. Transportation routes in northern Canada are oriented longitudinally, reflecting links of dependency on southern Canada. There are very few east-west networks connecting communities across the north. Rather than developing a central core of their own, northern regions tend to interact with the nearest urban centre to the south. The transport links that do exist may not be readily accessible to northern residents because of the prohibitive cost resulting from vast distance and high fuel costs. As well as the cost, reliability of transportation in the north becomes an issue where climate conditions frequently make surface travel dangerous and interrupt already irregular air schedules.

At first glance, the economy of the Canadian north may appear similar to rural southern regions in that primary production activities predominate. There are two striking features of the northern economy, however, that set it apart from the southern rural experience. The first feature is that subsistence hunting and gathering activities coexist with the market-oriented industrial society. Over time, the subsistence economy has developed complex ties of dependence with the industrial economy; northerners who choose to "live in the bush" for periods of time are still influenced by economic, social, and political decisions made in population centres to the south. The second major feature of the northern economy is that development has been imposed upon the region in powerful episodic waves related to the needs of the south (gold rush, military requirements, mineral & oil extraction, recreation, pulp mills) not the needs of the north. Northern economies depend almost entirely upon outside development capital and markets over which they have no control.

This brief description of the north is not intended to suggest that all of these features constitute problems for mental health services. Rather, they are presented as evidence to support the argument that northern Canada is qualitatively different from those settings considered in the rural practice literature. Several recent Canadian authors have made a distinction between rural practice and remote practice. The European Centre for Social Welfare Training and Research wrestled with this same issue and similarly proposed a new "remote" or "isolated" practice category (which they applied to northern Canada, northern Scandinavia, Alaska, and the mountain area of Yugoslavia).

Each Canadian province has the authority to define its own northern region using its own criteria. Many have determined northern boundaries and then assigned specific departments or councils to manage the region. Looking specifically at Alberta, the Northern Alberta Development Council is a 10-member advisory body reporting directly to the provincial legislature on matters concerning the northern 60 percent of the province. The precise southern limit of this region is determined by the uneven boundaries of the 10

Improvement Districts, five Municipal Districts, and three Counties that make up the NADC area (see NADC map at front).

Although the focus of this study is clearly on the NADC region, this area has much in common with the "top portions" of many other provinces. The Institute of Public Administration of Canada has observed that such provincial norths generally have not been recognized as unique populations for assessing needs and establishing vision. Instead they have been created after the fact as administrative regions for purposes of service delivery. These northern regions have been described as "subprovincial bureaucratic constructs" stuck with management structures imposed from the south. Through this study, the NADC is creating an opportunity to look at northern Alberta as a unique region, a primary unit where problems may be defined in northern terms, and not just a bureaucratic extension of the south.

One additional important point must be made as part of this discussion of the north. As anyone familiar with the region will know, there are many "norths" within the north. The NADC area includes a vast range of physical environments supporting communities of various size and ethnic composition, relative degrees of isolation, and vastly different histories of development and exploitation. While all of these settlements may have some common issues and themes by virtue of being situated in the north, one would expect to find considerable variation in the person-environment interaction from community to community.

Services

Acceptance of the interactive definition of mental health clearly implies a view of *mental health services* that goes beyond professional treatment of mental disorders. If mental health problems are "disruptions in the interactions between the individual, the group and the community," then it follows that *services* can be understood as any efforts to promote subjective well-being, justice, equality, or a nurturing environment. From this perspective, the helping process is as concerned with support as it is with planned change, a concern with promotion alongside prevention and treatment. At the field level, the concern includes, "how can existing resources, whether formal or informal, be encouraged, maintained and developed?" rather than simply "what needs to be changed or added?"

Such an expanded notion of service has two major implications for this study. First, mental health services are not limited to the programs offered by mandated social agencies with professional or volunteer staff. Other local forms of support and indigenous helping networks must be included. Second, mental health services will be community-specific. If mental health involves a dynamic interaction between persons and their environment, then one would expect to find a unique configuration of problems and resources in each environmental setting. An examination of mental health services in northern Alberta must look at the mix of professional and non-professional, formal and informal resources required by local persons to promote healthy functioning in their community as defined by that community.

Other Jurisdictions

While this study will focus specifically on mental health service delivery issues in northern Alberta, there is much to be learned from the experiences of communities and service providers in other northern regions. Published accounts of programs from across the north suggest possible alternatives regarding such things as worker roles, local support networks, management structures, recruitment approaches, and community-based service delivery. These strategies from the literature have been summarized in Appendix A.

Part II
Identifying the Issues

Review of Provincial Reports and Innovative Projects

Fifty-eight documents were reviewed to obtain background information about the issues and solutions that have been identified by those concerned with health services in northern Alberta. These documents have been divided into two categories:

- Northern Reports — including briefs submitted to NADC, NADC-sponsored reports, and other northern specific reports
- Provincial Reports — addressing health service delivery issues provincially and regionally.

An annotated bibliography of the reports is provided in Appendix B.

In addition, four innovative projects aimed at facilitating coordination and cooperation among service providers and agencies in northern Alberta were reviewed.

A brief summary of some of the relevant characteristics of northern Alberta, as noted in a number of the documents, is presented first, followed by a synopsis of the reviewed documents and innovative projects.

Northern Alberta

Sparse population, transportation systems, and community and cultural diversity in northern Alberta were viewed by many authors as important factors that must be taken into consideration in the design and delivery of mental health services in the region. The population figures and other statistics that follow are contained in the report *Trends in Northern Alberta: 1970 – 1990.*

Sparse Population

Northern Alberta, as defined by NADC boundaries, accounts for about 60 per cent of Alberta's land mass. The population of northern Alberta is approximately 254,000, which is just over one-third that of either Edmonton or Calgary. Only one-quarter of the population resides in its two major cities, Grande Prairie and Fort McMurray. The largest proportion, 47%, resides in rural communities with under 1,000 people. The remainder resides in communities that have a population of between 1,000 and 6,600.

The sparse population base was noted as having a number of implications for the delivery of human services:

- restrictions in the amount of funding that the region collects at a local level, and receives from higher levels of government
- a more limited pool of volunteer resources
- difficulties in disseminating information, particularly to isolated areas, regarding the availability of services
- the need for some people to leave their communities to access services, on the one hand, and for some professionals to travel to communities to serve their clients on the other.

Mobility

Transportation systems in northern Alberta are closely linked to economic development activity. Early on, river transport was developed around the fur trade. The railroad was introduced later to accommodate expansion in agriculture. More recent developments in highway and air transportation have resulted from economic expansion primarily in energy, forestry, and agriculture.

While mobility in northern Alberta has improved greatly, the following concerns were noted:

- Most major road links run north-south, with east-west links less developed or nonexistent.
- Public transportation services (e.g., buses, trains, etc.) are either not available or poorly developed in many communities.
- Some communities still have poor road systems or roads that are seasonal, and four communities are accessible only by air.

The need to travel both to obtain and provide service, combined with transportation difficulties, was noted in many reports as one of the more important impediments to mental health service delivery.

Community and Cultural Diversity

It has been acknowledged in Alberta that rural and urban areas are different and that the needs of each must be recognized in planning and delivering

services. The connotations of urban and rural, however, do not adequately define the range of northern Alberta communities. Within the area covered by the NADC (see map attached at front), there are two cities, 26 towns, 14 villages, three counties, five municipal districts and 10 improvement districts. A number of the unique challenges in service delivery that this assortment of communities provides were noted:

- Smaller centres frequently depend on towns and cities for service. When larger centres have service gaps or suffer difficulties in filling professional positions, the smaller communities suffer disproportionately, and essentially end up having little control over the availability of services in their area, particularly professional services.
- Resource-based centres are relatively young with a high transient population. These communities often lack a sense of "community" and the informal, family, and community-based support networks of more established centres.
- Older, more established agricultural centres typically have strong networks in place and a strong sense of community. The potential lack of anonymity in accessing mental health services, however, is often a concern.
- The economies of many communities are not significantly diversified, and are largely controlled externally, leading to high economic uncertainty and community stress.

Another relevant characteristic of the north is its large native population. There are 68 Indian reserves in northern Alberta. In total, approximately 13,500 native people live within the NADC area (this represents about 5% of the population in the north). In addition, there are eight Metis settlements with a total population of around 5,200. Several characteristics specific to the native population were noted in a number of the documents reviewed. These include:

- changes in traditional ways of living — brought on by economic development and often resulting in the native population being unable to fish, trap and hunt — that have led to employment and financial problems, alcohol and drug abuse, family violence, and other social or mental health problems
- intergenerational problems that are difficult to overcome
- language barriers and cultural differences affecting access to and the suitability of services for the native population
- reluctance of women to leave the support of family and friends, or social pressures to remain in destructive relationships
- split in responsibility and lack of integration and coordination of service provision between federal and provincial governments.

Many of these characteristics, while shared to some extent by some southern communities, are unique to northern Alberta in scope and degree, presenting additional challenges in meeting the mental health needs of northern residents.

Synopsis of Northern Reports

The documents in this group include briefs submitted to NADC, reports sponsored by NADC, and other northern-specific reports. A number of the reports, particularly *Future Health Care in Northern Alberta: A Position Paper* and *Human Services in Wabasca/Desmarais: A Review*, include extensive reviews of other documents which, consequently, are not reviewed separately here.

Although these reports do not focus specifically on mental health services, they refer to mental health needs and identify issues or strategies that are applicable to mental health service delivery. Many of the reports identify similar issues, and many of these appear to have remained relatively consistent over time. For example, a 1980 workshop on health needs in northern Alberta (see *Future Health Care in Northern Alberta*), along with a number of other more recent reports, note the uniqueness of the "north" and the importance of acknowledging its characteristics when looking at strategies for improving service delivery.

Staffing and Resource Issues

Key concerns expressed regarding program staffing and funding were:

- the high cost of living in the north and difficulties recruiting and retaining staff
- insufficient funding for mental health resources,

both professional and non-professional

- lack of training and continuing education opportunities
- lack of collegial interaction, particularly in isolated areas.

Urban areas tended to be more concerned with the need for "professional" staff (e.g., psychologists and psychiatrists), whereas in other briefs submitted to the NADC, qualifications were of less concern than the need simply to fill vacant positions. Parallels can be drawn to similar issues expressed regarding recruitment and retention of teachers in the north (*Early School Leavers in Northern Alberta*).

Solutions proposed to deal with staffing issues include:

- better recruitment and retention strategies
- increased salaries for mental health professionals and non-professionals
- returning subsidy training programs
- peer networking
- regular inservice training and upgrading
- training of local residents to supplement professional staff or to fill vacant mental health positions
- including orientation to rural and northern practice in the curriculum of professional training programs
- making potential recruits aware of the opportunities available in northern Alberta.

A strategy suggested in *Future Health Care in Northern Alberta* is a "from the north, trained in the north, for the north" concept of primary health care professionals, crystallizing the concerns expressed regarding the high turnover and apparent unsuitability of many urban-born and trained professionals.

Service Needs or Gaps

Gaps in service was one of the most frequently raised issues in the documents reviewed. Some of the specific concerns expressed include:

- inequities in services available to residents in rural and remote areas, relative to those in towns and cities, and gaps in services created by dependence on larger centres that themselves are having difficulties mounting programs and retaining staff
- lack of prevention, health promotion, and early intervention services
- inappropriate use of institutional services due to a lack of community-based treatment services
- lack of crisis intervention services.

The issue of health promotion and prevention of social and mental health problems was seen as a priority in several of the reports. Community-based programs were seen as essential to providing better access to services for those not yet in crisis and thereby to reduce the pressure on crisis intervention and treatment services.

Future Health Care in Northern Alberta recommends a prevention-oriented and community-directed health care philosophy. The report states the need for active health campaigns and education programs that promote a positive philosophy of prevention and well-being. Other reports suggest the need for expansion of citizen awareness, education, and media programs that take into consideration northern characteristics. Involvement of school divisions in providing health promotion and prevention programs was also recommended.

Service Delivery Models or Mechanisms

While many of the documents reviewed expressed the need to consider the unique characteristics of the north in designing and delivering mental health services, few proposed alternative service delivery models or mechanisms. Most recommended adjusting the existing system by filling gaps or rectifying deficiencies, rather than changing fundamental relationships within that system. Some documents addressed the concept of "regionalization" of services, such as satellite family violence centres and regional crisis lines, and pooling of resources.

The Community Mental Health Needs Assessment Report and Recommendations: Lesser Slave Lake Indian Regional Council initiated and tested a small community-based counselling program in 1984. The program provided education, counselling, referral, consultation, and research. The

difficulties encountered were similar to those experienced by existing services, including travel distances, caseload restrictions, continuity of care with services outside the area, and allocation of responsibility between federal government and Council programs.

The report, *Future Health Care in Northern Alberta*, recommended the development of a northern model for health care delivery. This model would recognize the unique requirements of the north and integrate all institutional care, community health, occupational health, home care, and social services as well as fiscal and administrative responsibility. The objective would be to provide health services, health-related prevention programs, and fiscal and administrative activities in a more coordinated and efficient manner. The development of mobile health care services was also recommended.

Service Coordination

In areas where little service exists, coordination was not raised as an issue, whereas it was a concern in areas where more service agencies exist. Coordination among government and non-government service providers was seen as particularly important in narrowing the gaps between services. Implicit in the coordination of services was the notion that available resources could be stretched further if agencies work together. Communication of information about available services in the area was also viewed as important. Lack of information or awareness of available services can result in a strain on more well-known resources.

Many documents reviewed suggested that interagency coordination be improved, but they did not suggest what models should be used.

Community Role and Involvement

A common theme underlying the reports and briefs was the need to strengthen the role of the individual and natural helping networks in service delivery, and to coordinate service delivery within a broadly-defined continuum of care model. Also common, was the need for appropriate mechanisms that would allow for a greater partnership among provincial and municipal governments, and community groups and boards, in the planning and delivery of services and in the development and monitoring of community standards and priorities through the transferring of responsibility, accountability, and adequate funding for meeting the needs of northern residents to communities or groups of communities. The need to enable native people in particular to become more economically self-sufficient was also noted.

Synopsis of Provincial Reports

The reports in this category address health service delivery issues provincially and regionally. They set out the principles, values and goals that should be considered in developing and planning health services, including the range of mental health services that are the topic of this report.

Professional and Resource Issues

Two of these reports (*Mental Health in Alberta II: the Present Mental Health System* and *The Rainbow Report: Our Vision for Health*) point out that about 90% of the mental health professionals (psychologists, social workers and psychiatrists) practise in Edmonton or Calgary, leaving few who practise in the rural settings, and fewer yet who practise in northern remote settings. Recommendations for increasing the number of mental health professionals working in the province include: incorporating mental health training in the curriculum for professionals; and creating a provincial mental health institute and an accredited clinical psychology training program in Alberta. Suggestions for increasing the number of professionals working in rural settings include:

- providing cross-cultural training in the curricula for mental health professionals
- training "natural care givers" in the community
- enhancing monetary incentives for rural practitioners
- insuring access to psychologists and social workers through provincial payment schemes.

The provision of compensation (under AHCIP) for professionals to provide consultation to other community resources was also recommended. This was considered a necessary and important step in changing the role of mental health professionals from that of primary care givers to that of consultants.

In a discussion of the current mental health care

system (*Mental Health in Alberta II: the Present Mental Health System*), it was pointed out that 88% of funding goes to institutional care, and that approximately one-third of mental health clients receive 90% of the total budget. These realities were considered to represent a systemic imbalance that influences virtually all other service delivery strategies — for example, the failure of the system to match, with the appropriate allocation of money, the trend or philosophy for more community-based care.

Service Needs

The service needs to fill gaps most clearly articulated in these reports include the following:

- more community-based programming
- accompany mental health treatment with efforts to reduce social problems and stress factors in society and "disorganization" (*Mental Health in Alberta I: Philosophical Issues*) of social structures
- provide treatment services for those with early signs of mental illness and mental health problems
- a separate children's (including adolescents) mental health service
- native mental health services that more adequately comprehend the "native situation" (*Exploring the Circle: A Journey Into Native Children's Mental Health*).

Service Delivery Models or Mechanisms

In the discussion paper, *Mental Health Services in Alberta: Sharing A Vision of Better Health*, principles for planning and providing mental health services were outlined, as paraphrased below:

- Effective mental health services require partnership among the family, community and government.
- There should be a continuum of services available through collaboration of service providers, as resources permit.
- The system should maintain and strengthen individual, family, and community resources; facilitate independence and respect personal lifestyle; and provide care at the least intrusive level consistent with the client's needs.
- The focus of care, where hospitalization has been required, should be to take all steps that are necessary to use community-based rather than institutional services.
- The system should assist clients in choosing services required to maintain and restore their mental health.

This document also recommends that people living in rural areas should have access to "generic — basic services", including "access within a reasonable distance to a mental health worker, a physician and to general hospital care for the purpose of addressing a mental health concern." Expanding on the theme of "generic" mental health services, the report, *Sharing Solutions: Towards a Master Plan for Service Delivery to the Mentally Ill*, identified the following key mental health services: community mental health clinics; psychiatric in-patient services; day programs; case management; crisis services; housing services; and vocational rehabilitation. Other components of the system would vary according to local needs.

An important principle expounded in the *Rainbow Report: Our Vision for Health*, is that "basic [health] services would be fully insured, accessible to all and paid for out of the public purse." In order to achieve this, the report recommended:

> . . . that the government of Alberta, in consultation with health care practitioners and consumers, *define* what it considers to be basic insured services covered by the Alberta Health Care Insurance Plan (Volume 1, p. 36; emphasis not in the original).

In each of these cases it is clear that basic or generic health services need to be defined before a system can be put in place to deliver those services equitably to all Albertans. In the two documents that deal with basic or key mental health services cited above (*Mental Health Services in Alberta* and *Sharing Solutions*), it would appear that a start has been made in this direction; however, differences in these two definitions of basic mental health services exist, and will need further clarification. A recommendation made in the report *Changing Thinking and Thinking Change*, was for the development of a comprehensive mental health services act. Those charged with the development of such an act would clearly need to wrestle with the notion of basic mental health services.

The three-part draft report *Mental Health in Alberta* recommends that future service delivery models focus on the following:

- basic societal structures, such as strengthening communities and families to help prevent the manifestations of social and mental health problems
- mechanisms that will allow for movement of resources as needed, allowing for the system to self-correct, and which will promote and reward efficiencies
- mechanisms that promote, facilitate, and financially support a mental health consultation model so that the network of practitioners who provide service is expanded
- support in fostering the native community's move toward independence.

Community Role and Involvement

Three important policy documents (*Changing Thinking and Thinking Change; Sharing Solutions: Toward A Master Plan for Service Delivery to the Mentally Ill*; and *The Rainbow Report: Our Vision for Health*) echoed the idea advanced in many of the reports reviewed earlier that authority for the provision of health services should be transferred from central bodies to local or regional bodies. It was also suggested that consumer advocacy groups be established at the local level to inform the regional authorities. Modifying the role of the professional from that of a primary care provider to that of an educator and consultant can also be seen as a step toward encouraging and supporting local communities to assume greater control of mental health service delivery.

Innovative Projects in Northern Alberta

Four innovative projects have been established in northern Alberta over the past few years to facilitate coordination and cooperation among mental health service providers and agencies. Three of these projects: Spectrum in Grande Prairie; Venture in Fort McMurray; and Insight in St. Paul, involve agreements between hospital boards and Alberta Mental Health as well as other agencies. The fourth involves an agreement between Alberta Mental Health and Alberta Family & Social Services in the northeast region. It enables Mental Health and Child Welfare to work together and combine their resources so that mental health services to children in the region may be improved.

Each of these projects, though still in developmental stages, appears to have substantially improved service coordination and cooperation, and is strongly supported in the respective communities and regions. Spectrum, Venture, and Insight are closely linked with designated psychiatric hospitals in their communities, and therefore tend to be limited in scope to communities with such facilities. Advocates believe, however, that components of these programs can be successfully implemented in smaller communities without psychiatric hospitals. See Appendix C for more details regarding these innovative projects.

Community Visits

Important information concerning mental health service delivery in northern Alberta was collected through visits to 10 separate communities within NADC boundaries. The communities visited were:

- Beaverlodge
- Falher
- Fort McMurray
- Grande Cache
- Grand Centre
- High Level
- Lac La Biche
- Swan Hills
- Wabasca-Desmarais
- Whitecourt

The purpose of the community visits was three-fold:

- To raise awareness throughout the north of mental health issues
- To identify how and to what extent the various issues identified in the documentation and literature manifest themselves in different northern communities and regions
- To gain insight to how communities are responding to local needs through creative or innovative strategies that might be used by other communities facing similar issues.

The communities were not chosen because they necessarily represented "problem" communities; rather, they were selected as independent "case studies" representing the spectrum of communities found in northern Alberta, including urban, rural, remote, agricultural-based, resource-based, native, growing, stable and declining, or some combination of these characteristics. It was recognized that these different types of communities might be experiencing different socio-economic pressures and may, correspondingly, have differing service needs and differing approaches to meeting these needs.

Each community visit was one day in length, and was conducted in essentially the same manner: a meeting with an interagency group of service providers in the morning; a meeting with individual service providers in the afternoon, and a "Town Hall" meeting with community residents in the evening. (Confidential interviews were also conducted in the afternoon with clients/consumers of mental health services. Findings based on client interviews will be addressed separately in the next section of this report.)

Summarized notes from each visit are contained in Appendix D. It should be pointed out that the comments, needs, and solutions documented in Appendix D are those expressed by the participants, and do not necessarily reflect the views of the consultants, the project steering committee, the NADC, or the Alberta government. Time did not permit independent corroboration of the problems and needs in each community, although there is no reason to suspect that the concerns expressed by service providers and residents are invalid.

Findings have been summarized in Tables 1 to 6 that follow. These tabulations have a number of limitations that should also be noted:

- A great deal of information was collected from a large number of individuals in a relatively short time frame. Interpretations by the consultants of comments made by community participants may not always accurately reflect the meanings intended.
- Not all community stakeholders participated in each visit. Therefore, failure to record a particular concern in a given community does not mean that the concern does not exist, only that it was not registered or recorded during meetings and interviews at that community.

Community Profiles

Before commenting on mental health service issues, participants were asked to discuss their community's history and some of its strengths and weaknesses that might reflect on the mental health of residents. Table 1 summarizes the comments recorded for each community.

Typical of many communities in northern Alberta, particularly resource-based communities, six of the 10 communities visited were relatively young and reported a significant transient population. The other communities were older, relatively more established, and were agricultural-based or native.

Table 1

Community History, Strengths and Weaknesses

(An X indicates that the issue in the left hand column was mentioned in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
History/Environment										
Significant transient population	x	x	x		x	x	x	x		x
Periodic boom and bust cycles				x	x	x				x
Several distinct communities/cultures	x				x	x	x			
Relatively young community			x	x	x	x		x		x
Relatively old/established community	x	x				x				
Disparity between rich and poor				x		x	x			x
Strengths										
Esthetics/pace/lifestyle	x	x		x		x		x	x	x
Friendliness/Helpfulness	x		x	x		x		x	x	x
Resurgence in native traditions							x		x	
Community activism/dynamism	x		x	x	x	x			x	
Cooperative interagency group	x	x	x	x					x	x
Self-contained service area			x							
Pool of professional/volunteer resources		x		x	x	x		x		
Large government employer				x			x			
Good employment opportunities										x
Good base of human services					x	x				x
Extended family network	x	x				x				
Establishment of second generation				x		x		x		
Less transience/more settled				x		x		x		
Awareness of mental health issues/services	x	x		x						x
Municipal support for FCSS		x		x	x			x		
Weaknesses										
Loss of traditional ways/values		x				x			x	
Community politics/cliques/isolation		x	x			x		x	x	
Loss of neighborly/small town spirit	x	x		x		x			x	
Lack of employment opportunities	x			x	x	x	x		x	x
Lack of post-secondary education									x	x
Lack of recreation/cultural activities	x			x		x		x	x	
Greater problems with new/transient people			x							x
Lack of extended families/resources			x	x	x	x		x		x
Dependence on large employer			x	x						
Significant shift-work			x	x		x		x		
Lack of community continuity with turnover					x					
Friction between old and new residents							x			
Competition/stress/lack of family time	x			x		x		x		x
Lack of volunteer time/energy						x				x

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

Transience in these communities relates more to turnover in family farms (and in the AVC student population in Lac La Biche). In some communities, transients are seen as bringing a disproportionate number of problems with them, further stressing available services. This is not the case in the younger communities, although some are beginning to see the emergence of a "second generation" as the community matures.

Many participants mentioned the beautiful scenery, slower pace of life, and general friendliness and helpfulness of community residents as a major advantage of living in the north. At the same time, however, a number of communities appear to be losing the "small town" atmosphere with growth from economic development, and are experiencing increasing levels of community stress because of recent economic problems, competition for jobs, and pressures on family time from shift-work (resource-based communities) or having to hold down a second job to make ends meet (farming communities).

Communities like Grande Cache that have weathered the most recent boom and bust cycle appear to be coming into a more stable period, although the fabric of the communities has been permanently altered. The farming and native communities also have been faced with significant changes to traditional lifestyles linked to the "land". The older communities typically have established family and community networks in place that relieve some of the pressure on formal services. This is not the case in the younger communities, although some are beginning to see the emergence of a "second generation" as the community matures.

Newcomers in both young and old communities can experience problems with isolation. The remoteness and isolation are a strength for those who have chosen to live in the north, but not for some who have been transferred in, particularly if they are reluctant to become involved in the community. Despite the generally friendly atmosphere that prevails in many northern communities, residents tend to be more reserved about investing in relationships with newcomers who may soon move away.

Several of the communities have indicated a growing trend toward greater community responsibility and activism, spawned partially out of frustration with cutbacks in provincially supplied services, and out of growing awareness within the community-at-large of mental health issues. Several communities reported good municipal support for FCSS, as well as stronger interagency communication and cooperation. Several communities also reported strong volunteer support, with a good pool of professional resources to draw upon, many brought in through the transient labor force.

The general sense is that many northern communities have experienced rapid and dramatic changes in the last 10 years that have taken their toll through dislocation, uncertainty, and general disruption of individual, family and community life. These pressures wax and wane in individual communities according to differing economic cycles, but remain an important influence on mental health as the north continues to develop and evolve.

Service Gaps and Weaknesses

Table 2 summarizes the service areas that were reported either weak or lacking by participants in each community. Again, it should be remembered that communities may well experience additional service gaps or weaknesses beyond those reported, although the most serious gaps are likely recorded in the table.

The service areas have been divided into categories as follows:

- *Prevention/Promotion* — services geared to maintaining or enhancing mental wellness by enabling individuals to cope with the stresses of life
- *Pre-Crisis* — "early intervention" services for individuals and families having difficulties coping with stress, but not immediately at risk
- *Crisis Intervention* — short-term intervention services geared to dealing with an immediate crisis involving violence or suicide
- *Assessment and Treatment* — assessment and longer-term treatment services dealing mainly with diagnosed mental illness or severe social coping problems

Table 2

Service Gaps and Weaknesses

(An X indicates that the issue in the left hand column was mentioned as lacking in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
Prevention/Promotion										
Prevention		x			x	x		x		x
Promotion					x	x		x		
Education/courses (life skills)		x			x			x	x	x
Pre-Crisis										
Youth programs/activities/groups		x	x	x				x	x	
Teen drop-in centre				x				x	x	
Student guidance/counselling		x				x	x			
Family-school liaison						x			x	x
Early intervention		x			x	x			x	
Family counselling		x		x	x	x		x	x	
Family outreach					x				x	
Family respite						x		x		
Mothers' respite/groups/activities								x		
Child/Day Care			x					x		
Fathers' respite						x				
Singles' activities/groups						x		x		
Peer support groups		x						x		
Group homes						x				x
Youth group/day home				x						
Emotional Support		x								
Information/referral							x			
Crisis Intervention										
Suicide/crisis intervention/counselling	x	x		x	x			x		
Crisis line	x	x		x	x	x				
Women's shelter					x			x		
Men's hostel/retreat						x		x		
Assessment/Treatment										
Assessment/treatment (long-term)										
- Psychological	x	x	x	x	x	x	x	x	x	
- Psychiatric			x	x	x	x	x			
Alcohol/drug abuse counselling	x	x	x	x				x	x	x
Sexual abuse counselling			x	x	x					
Family violence counselling				x	x		x			
Residential youth treatment facility			x							
Post-Treatment										
Transition facility						x		x		
Community-based follow-up/support groups		x	x		x	x		x	x	

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

- *Post-Treatment* — long-term community-based follow-up after completion of treatment.

It is assumed that a comprehensive mental health service network will be capable of providing accessible services in each of these areas.

Prevention and Promotion Services

Agencies in many communities commented that they are unable to adequately provide preventive services, largely due to crises that are backing up into their caseloads because they have no place to refer clients. It was commonly mentioned that Alberta Mental Health can only see clients at immediate risk. Less urgent cases are seen by local agency staff who have not been trained to deal with them, and who then are deflected from prevention and promotion programming.

Pre-Crisis Services

This area of service was frequently mentioned as weak or deficient. Where such services are available they are typically community-based and operated by local agencies with paraprofessional and volunteer staff.

Many communities were concerned about their youth, both those in school and young adults struggling to find work in the community. The need for youth programming, including groups, drop-in centres, guidance counselling, and school-family liaison work, was frequently mentioned. Several poignant comments were made regarding the need for earlier intervention in dealing with youth coping and behavioral problems that manifest themselves in the school system, but that frequently are not dealt with until crises arise.

The other major area of concern was family services, particularly family counselling but also outreach programs, child day care, activities for mothers, and respite (mother, family, father) programs. Although many communities recognized the need for more family counselling services, few agencies are formally mandated for this role. In some cases, FCSS has attempted to fill such gaps, despite restrictions in its mandate and budget.

Crisis Intervention Services

Six of the 10 communities expressed concern over crisis intervention services, including crisis lines and local crisis response. Crisis lines in several of the communities were unreliable, depending on under-trained volunteers or on-call staff. A few communities expressed concern about lack of coordinated and effective response by local police, medical, and counselling resources.

Assessment and Treatment

Essentially all communities expressed concerns about the availability of professional long-term psychological and/or psychiatric treatment services in their communities. Few communities have psychiatric hospital beds or psychiatric day programs. Most communities depend on Mental Health and AADAC workers from another centre. Staffing cutbacks, vacancies, and high caseloads in Mental Health often undermine the development and/or support of community-based services. Many clients are required to travel outside their communities for professional care.

The lack of local counselling for both sexual abuse and family violence victims and offenders was also noted in several communities.

Post-Treatment Follow-up

Many communities expressed concern about the lack of local follow-up for clients returning from or treated by professionals in another centre. Need was expressed for more local self-help support groups and transitional facilities to complement external services and provide better continuity of care for clients.

Service Impediments

While it is important to make note of some of the mental health service gaps and weaknesses experienced by northern communities, it is equally important to understand why these gaps exist. Table 3 summarizes the impediments to service delivery expressed by respondents in each community. The comments have been broken into three categories as follows:

- *Client Impediments* — factors that prevent or hinder clients from accessing services needed
- *Agency Impediments* — factors that prevent or hinder agencies from developing and delivering services needed in the community
- *Staff Impediments* — factors that prevent or

Table 3

Service Impediments

(An X indicates that the issue in the left hand column was mentioned as a service impediment in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
Client Impediments										
Distance/transportation	x	x		x	x	x				
Lack of local services	x					x	x		x	
Lack of awareness of services/rights		x			x	x		x	x	x
Lack of knowledge of symptoms/problems								x	x	
Stigma/confidentiality/trust concerns		x	x	x	x	x				
Lack of choice of worker/service							x			
Lack of culturally relevant native services			x	x			x			x
Agency Impediments										
Underfunding/understaffing/waiting lists	x	x	x		x		x	x	x	x
Crises backing up into agency caseloads	x	x			x		x	x		x
Insufficient use of local resources		x	x	x		x		x	x	x
High reliance on outside professionals			x	x		x		x		
Services vary with incumbent					x	x				
Excessive agency/system overhead				x					x	
Lack of funding continuity/equity	x		x	x				x	x	
Low priority of mental health					x					x
Lack/irrelevance of statistics				x				x	x	
Agency policy/mandate restrictions				x		x			x	x
Lack of client advocacy groups						x				
Lack of facilities								x	x	
Lack of community development skills						x			x	
Staff Impediments										
Insufficient skills to deal with cases	x	x	x			x				x
Travel overhead/downtime	x				x	x		x		
Difficulty in gaining trust/acceptance										
- local paraprofessionals									x	
- outside professionals						x			x	
Lack of prof. support for paraprofessionals	x	x								

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

hinder individual service providers from meeting the needs of clients.

Client Impediments

One of the more frequently noted impediments to clients accessing services was the lack of local services and the time and cost required to travel outside the community to receive services. This was considered a major deterrent for many clients who find it impossible to complete their treatment program because of the inconvenience and stress associated with frequent travelling over significant distances. Lack of affordable public transportation was considered a further hindrance for some clients.

Many communities also suggested that the public is not always aware of the services that are available and of its right to use them. It was also mentioned that people are sometimes ignorant of stress and mental illness symptoms and often do not even realize they may benefit from service.

Several communities suggested that people in small towns are concerned about the inherent stigma associated with using mental health services, and can be reluctant to seek help. Confidentiality was considered an important factor in a client's decision to access services in smaller communities. It was stated that clients sometimes prefer using an external service if they have the choice, although use of a local paraprofessional resource was not considered a major barrier

provided the individual is trained, well regarded, and ethically conscientious in terms of client confidentiality. Appropriateness of services was considered an issue for natives who frequently do not have access to culturally relevant services.

Agency Impediments

Perhaps not surprisingly, one of the most frequently noted impediments to service delivery was lack of funding or lack of staffing, resulting in waiting lists for service, hindering regular service including prevention and promotion efforts, and frequently causing crises to back up into agency caseloads. Several communities complained that funding was inconsistent and undependable, frustrating agency attempts to implement programs. Excessive overhead was attributed to many programs being established on a pilot or year-to-year basis, requiring frequent and time-consuming preparation of funding proposals, and several agencies (local and provincial) unnecessarily duplicating overhead expenses for such items as space, reception, and clerical/administrative services. There was also some concern that funding formulae used to allocate resources provincially are inequitable. They reflect too low a priority for mental health in general, and do not adequately compensate for the higher cost of living, travel downtime, and training overhead (i.e., training of workers who leave to take positions in the south) borne by northern agencies. It was also noted that agencies have difficulties collecting the statistics required by funding authorities, and that the type of statistics requested do not always reflect true community needs.

Many communities commented that not enough use is made of local paraprofessional resources available within the community. A number of comments were made that communities rely too heavily on external professionals, and that services tend to vary with each new incumbent.

Some communities suggested that service gaps can be created because of agency policy or mandate restrictions that cause certain target groups to "fall through the cracks." Workers tend to be accountable to their agencies rather than to the communities they serve, and do not always have the flexibility to adjust their role to meet the needs of the community. The lack of client advocacy associations in smaller communities can also result in a shortage of services for special needs groups. While issues surrounding mandate and flexibility in worker role were frequently noted, many communities also suggested that, out of necessity, agencies often bend the rules in order to respond to the needs in the community, and that many creative and innovative projects have been initiated through interagency coordination and cooperation.

A variety of other impediments were also mentioned including: lack of facilities to hold meetings and peer support groups; and lack of community development skills to organize grass-roots solutions to service gaps or needs. The capacity for grass-roots development of services appears to vary among communities depending on their histories and the leadership shown by key personalities.

Staff Impediments

Service delivery staff also face impediments in providing service. The most frequently mentioned concern was lack of skills, particularly among paraprofessionals and volunteers who are increasingly forced to deal with crisis situations intruding into their caseloads. Staff do not always feel competent in dealing with such cases. Some concern was also expressed regarding the knowledge of general practitioners in mental health problems, and the appropriateness of the treatment and referral services provided.

Another impediment frequently mentioned was the downtime caused by travel in the north which can reduce productivity by 20% or more. Staff who have to travel simply cannot handle the same caseloads as staff stationed in a larger service centre. It was noted that with frequent turnover, staff sometimes have difficulties in gaining the trust and acceptance of community residents. It was suggested that a full year can be required before a new worker is "up to speed" in a community, implying significant loss of productivity if staff turnover is frequent.

Peer self-help and support groups using paraprofessional or volunteer moderators are active in many communities. It was mentioned that these groups tend to function more effectively and endure longer with involvement or support from professionals. Such support is not always avail-

able, depending on the caseloads of professional staff and the policy of their parent organizations regarding involvement in group work within the community.

Professional Issues

A wide range of concerns was voiced related to the recruitment and retention of mental health workers in the north. These concerns are summarized in Table 4.

Recruitment

Most communities commented on problems with staffing levels and difficulties in recruiting mental health workers to fill existing vacancies. The most common reason cited for recruitment difficulty was uncompetitive salary and benefit packages for northern workers that do not adequately reflect the higher cost-of-living or the more stressful working conditions. It was clearly felt that salary grids should be adjusted to provide greater incentive for workers to choose northern placements. Several commented that the private sector and school boards have made the adjustments, but that the provincial government has not. Others noted that northern workers do not have adequate representation in provincial unions and thus do not have advocates for their wage and employment issues.

Some felt that Alberta Mental Health was not doing enough to recruit workers, but others noted that there was a general shortage of qualified mental health professionals in the province because of a lack of clinical training programs in Alberta universities. Some suggested also that mental health services do not have a good image generally, and it is difficult to encourage people to pursue a career in the field.

Retention

The most frequently cited reasons for professionals leaving the north were related to the culture shock that southern workers suffer when they move to work and live in a northern community. Many experience the same isolation problems of their clients, and eventually leave the north, even though they may take positions with lower salaries in order to return to an urban setting.

It was also frequently mentioned that some southern professionals are unprepared for northern practice, and become disillusioned when their expectations are not met. Training in a southern clinical environment does not reflect the nature of

Table 4

Professional Issues

(An X indicates that the issue in the left hand column was mentioned as a problem in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
Recruitment										
Wages/incentives/cost-of-living	x	x	x		x	x	x	x		x
Lack of advocates for northern workers			x			x				
Insufficient recruitment efforts					x		x			
Insufficient supply of professionals	x									
Poor image/value of mental health services							x		x	
Retention										
Culture shock/isolation (workers/spouses)		x	x		x	x		x	x	
Unpreparedness for northern practice		x				x	x			
Restrictive mandate						x	x	x	x	x
Lack of collegial/peer support		x	x		x		x	x		
Lack of supervision					x			x		x
Stress/overwork	x						x	x		
Career path in city		x	x							x
Lack of local training opportunities		x	x		x		x		x	x

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

work in a northern practice. Many workers become frustrated by the restrictions imposed by agency mandates that prevent them from filling the role desired by the community. Many also work alone with relatively little of the supervision and collegial support necessary to cope with the emotional stresses typical in mental health and social service caseloads. Some find travel stressful, particularly in view of the distances, road, and weather conditions that prevail. Many also cope with large caseloads, exacerbated by travel downtime, that often result in long hours of work.

It was also suggested that many workers take northern placements only for the experience, and that their long-term career aspirations are in the city. Many workers, both professional and paraprofessional, are forced to leave the northern community in order to get further training because of a lack of local training opportunities. For many paraprofessionals living in the community, travel is a significant impediment to upgrading, causing the community to continue its high dependence on outside professional resources, despite the supply of "near qualified" local resources. Several comments were made regarding the apparent disinterest of Alberta universities in providing extension courses in the north.

Coordination Issues

Findings regarding coordination issues are summarized in Table 5. Most communities have established some form of interagency committee representing various service providers, both local and external. Some meet on an *ad hoc* basis, although most meet regularly, typically to share information and to facilitate the referral process by keeping acquainted with the various service providers and their current status. Several interagency groups have initiated joint projects where staff are cost-shared between two agencies, or where agencies collaborate in the delivery of services to specific target groups. A few groups have discussed closer integration of services through vehicles such as centralized intake and case management, although little progress has been made in these areas except in higher profile projects initiated specifically with these aims in mind. (See discussion on Innovative Projects in the previous section of this report; see also Appendix C.)

In some cases, agencies have initiated joint case presentations and consultations involving shared clients, although this is not widespread. Some comments were made regarding confidentiality and the ethics of sharing client information, although many suggested that appropriate protocols could be developed provided basic trust has been established between service providers regarding professional conduct.

A few communities suggested coordination problems at the funding levels, for example: between the federal and provincial governments regarding services to natives on and off reserves; with hospital and health unit boards regarding mental health service priorities; with school boards regarding "community schools" and the participation of non-teachers in health education for students; and between local government, industry, and agencies regarding funding for mental health services. Interdepartmental "turf" issues appear to be hampering coordination of service at the community level as well.

Table 5

Coordination Issues

(An X indicates that the issue in the left hand column was mentioned as a problem in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
Lack of Coordination										
- at local level	x		x	x	x	x	x	x		x
- at funding levels							x		x	x
- between external and local agencies	x	x		x	x			x		

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

Several comments were also made regarding lack of coordination between agencies at the local level and those at the provincial level, particularly with Alberta Family & Social Services (Child Welfare) and Alberta Mental Health. Local service providers sometimes feel "disengaged" after making a referral, and feel they should be more informed and involved in the client's treatment progress, particularly in a follow-up or support role once the client has returned to the community or has completed treatment. The concept of "teamwork" was mentioned, with suggestions that external professionals do not always consult with local service providers after referral.

Solutions and Strategies

In the course of interviews with service providers and residents in each community, a number of suggestions were made regarding strategies to overcome service impediments and to fill service gaps. The solutions are summarized in Table 6.

Funding Strategies

Implicitly or explicitly, most communities recommended increases in funding, both to improve the wages paid to northern workers and to increase the level and variety of services to northern communities. While funding concerns cannot be dismissed out of hand, the challenge is to find innovative solutions to mental health service delivery problems in northern Alberta under the assumption that funding will always be less than optimal. Sole concentration on funding issues *per se* would be too narrow and simplistic to address the range of issues identified in the communities.

It is reasonable, however, to consider whether the process for allocating funds within the province is equitable, and whether the north is getting its "fair share." A number of communities recommended that future funding formulae recognize and specifically compensate the north for staff productivity lost in travel, and for the training overhead northern agencies bear through providing supervision and work experience for university graduates who eventually leave to take positions in southern Alberta. It was also recommended that interagency coordination time be specifically budgeted for so that "service time" will be set aside for work required to design and implement innovative and cooperative mental health services.

Recruitment Strategies

A wide range of strategies were suggested regarding recruitment of mental health workers to the north.

It was recognized that the north will always require professional service providers, regardless of changes that may evolve in the future. Strategies to increase the pool of potential candidates for professional positions included such mechanisms as:

- encouraging educational institutions to place more students in rural field placement, and to collaborate with local agencies in providing the necessary supervision
- promoting the north (through videos, trade fairs, media advertising, etc.) to students and qualified professionals to make them more aware of the north as an alternative, and to enable them to better "screen" themselves regarding their suitability for northern practice
- covering psychological services under AHCIP, at least in centres having difficulty recruiting qualified psychologists, to provide greater incentive for professionals to consider northern practice
- recruiting professionals from outside Alberta/ Canada who will be more likely to consider a northern community as their permanent home, to get involved in the community, and to make a long-term commitment to practise in the north.

There was considerable comment made on the under-utilization of local paraprofessionals in northern communities. Several suggestions were made that the current relationship between professionals and paraprofessionals should be changed by cultivating, training, and employing more paraprofessionals to provide direct service, with external professionals serving more in a support role (education, consultation, case conferencing, etc.). One of the keys was training for paraprofessionals: providing bursaries for northern residents to pursue training in the city, and providing more local training opportunities through post-secondary extension programs.

Table 6

Solutions and Strategies

(An X indicates that the issue in the left hand column was mentioned as a solution or strategy in the community.)

	Communities*									
	B	F	F M	G Ca	G Ce	H L	L L	S H	W D	W
Funding										
Compensate for training/travel overhead		x	x							
Recognize interagency coordination time						x				
Recruitment										
Rural practicum placements		x	x		x					
Promote/advertise the north						x				
Psychological services under AHCIP		x	x							
Recruit outside of Canada			x							
Cultivate/train/use local paraprofessionals		x		x		x		x		
Bursaries for training northern resources			x			x				
Local training via university extension		x								
Cost sharing of positions					x			x		
Allocation of vacant payroll to HR			x							
Promote volunteerism/recruit newcomers				x				x		
Retention										
Minimum 3-5 year employment commitment									x	
Integrate northern practice in curriculum		x				x				
Orientation/cross-cultural training						x				
Community integration of newcomers									x	
Training and networking opportunities						x				
Consultation/inservice through distance ed.		x	x			x				
Accelerated grid — long service incentive			x			x				
Avoid single person offices		x								
Job sharing								x		
Community Role										
Community development				x		x				
Community-determined standards/methods				x				x	x	x
Community control over funding allocation		x			x			x	x	
Pool funding under community board									x	x
Alternate Delivery Mechanisms										
Support for/integration of local providers	x						x	x	x	x
Travelling mental health clinic						x			x	
Hospital as physical/mental health centre	x		x				x			x
Access to schools by other services	x					x	x		x	
Student assistance programs		x								
Mental health services through Home Care									x	
Home visits						x	x			
Privatization/evaluation mechanism							x			
Family counselling through FCSS							x			
Employers offer services to community					x					x
Regional crisis lines							x			
Single entry/coordinated case management					x	x				
Joint agency programs				x						
Client/Services										
Promote new image for mental health				x			x			x
Define basic mental health services							x			

* Beaverlodge (B); Falher (F); Fort McMurray (F/M); Grande Cache (G/Ca); Grand Centre (G/Ce); High Level (H/L); Lac La Biche (L/L); Swan Hills (S/H); Wabasca-Desmarais (W/D); Whitecourt (W).

It was also suggested that more value could be derived from existing funds currently spent on salary and travel costs associated with external professional resources. Several communities suggested that local paraprofessional staff, properly supported by professionals (consultation, case conferences, inservice, etc.), would be acceptable to community residents, and would in many cases be preferable to travelling outside the community, assuming an external professional was even available.

Other recruitment strategies included such things as:

- cost sharing of positions between agencies to provide a more attractive remuneration package and attract more highly qualified persons to the community
- reassigning personnel dollars from vacant positions to fund contract positions (e.g., psychologists) and to enhance recruitment and retention efforts (e.g., job advertising, incentive packages, bursaries, professional development, etc.) rather than returning the funds to Treasury
- promoting volunteerism within the community and, particularly, actively recruiting new community residents to become involved in human services, both for their own good (by way of easing their entry into the community) and for the good of the community.

All of these would require some redefinition and, in some cases, increased flexibility in service delivery roles.

Retention Strategies

A variety of mechanisms were recommended to improve job satisfaction and reduce turnover in mental health staff. These were:

- requiring a minimum commitment of three to five years for key mental health positions to improve the continuity of service
- integrating "northern practice" content as mandatory in the curricula of mental health training programs, and providing all new northern workers with a standard orientation on northern issues and service delivery approaches so they will be better equipped to make the transition to northern practice
- establishing a proactive community settlement/integration service for new workers and their spouses so they are less likely to suffer culture shock and become isolated
- providing more opportunities for northern workers to network with peers, both as a perk and to reduce feelings of professional isolation
- using distance education technologies to connect northern workers to professional support and inservice opportunities
- accelerating provincial salary grids to provide additional incentive for long service
- avoiding or abolishing single person clinics to ensure supervision and collegial support
- sharing full-time counselling positions between two professionals to reduce stress, improve collegial support, and generally enhance the attractiveness of positions in remote communities.

Community Role

A number of recommendations were made for devolving greater responsibility and autonomy to communities in meeting the needs of residents. These were:

- catalyzing community activism to foster the development of grass-roots solutions to service gaps
- regulating externally imposed priorities, policies, standards, and methods to allow communities more control over the variables influencing services delivered, and mental health workers more flexibility in meeting community needs
- delegating greater decision-making authority regarding allocation of funds for externally supplied services to the community so that local priorities are addressed.

These solutions imply a greater formal role for "community governing bodies" in relation to existing provincial agency policy makers, and greater accountability of workers to the communities they serve rather than the agencies they work for. Suggestions were made in a number of communities that funds currently flowing from provincial sources into the area could potentially be pooled with local funds and controlled by a local board that would take direct responsibility for

human services to area residents. Such a board would, for example, have the authority to hire staff directly, to contract staff, to contract provincial consultants or to fund community agencies, thereby enhancing coordination of services among agencies serving the area, and improving system accountability and responsiveness to local needs.

Alternative Delivery Mechanisms

In addition to options for funding and governance of mental health services discussed above, a variety of suggestions were made regarding new or alternative delivery mechanisms that would improve mental health service delivery. These were:

- integrating community-based paraprofessionals with external professional service providers as part of the "service team"
- establishing travelling mental health clinics consisting of professionals/specialists and practicum students who would visit communities on a regular basis to provide service (chronic cases), and to consult with and provide inservice to local paraprofessionals
- reconstituting local hospitals or other health centres as multipurpose health (physical and mental) treatment centres, with space for a wide variety of services (shelter, alcohol detox/ treatment, group counselling, meetings, outpatient programs, etc.); the hospital or health centre would serve a stronger community health role, helping to reduce the stigma around mental health services and improve overall coordination and efficiency of services
- enabling better access to school-aged children by other service providers, and fostering better teamwork between teachers and other local agencies in dealing with family problems manifested through the student
- establishing "student assistance plans" modelled after employee assistance plans in the private sector
- providing mental health services (psychiatric nursing care, social work, etc.) through the home care programs of local health units as a key access point to dysfunctional families
- providing more home visits to reduce the stigma and gain better access to families
- privatization and contracting out more services to private practitioners to make more effective use of local resources
- channeling funds from the recently announced provincial "family initiative" into family counselling services through the established FCSS network, rather than creating a duplicate delivery system
- encouraging large employers to make employee mental health benefits more widely available to other members of the community
- establishing regional crisis lines
- implementing single-entry access to mental health services with coordinated case management among agencies serving the same client
- establishing more joint ventures among agencies in implementing mental health programs and services.

Client/Services

Most strategies noted in community visits dealt with improvements to the "system" that would directly or indirectly improve mental health services to northern residents. Relatively few recommendations were made regarding the empowerment of residents themselves.

Several communities commented that mental health promotion and prevention efforts are being hampered by community and agency preoccupation with crises. A number of recommendations were made suggesting that promotion initiatives should attempt to change the image of mental health and reduce the stigma that prevents people from seeking help. It was suggested that promotional campaigns should convey the concept of mental wellness, that coping problems are common, that it is all right to talk about them, that services are available and that it is all right to seek help. It was also mentioned that people have a right to mental health services, and that "basic mental health services to which all are entitled" should be defined, both to provide a benchmark for services in Alberta communities, and to empower residents to access the services they require to maintain their mental health.

Client Interviews

As an integral part of visits to each of the 10 northern communities, confidential interviews were arranged with past and present users of mental health services.

It should be noted that the process of client selection was delegated to agencies in each community visited. Clients were not screened to ensure a representative sample was selected. The interviews were not intended to evaluate specific services in selected communities but rather to gain insight into service delivery issues from the perspective of users in the system, and to balance the feedback received from service providers.

Findings from these interviews are discussed below. Notes from client interviews have been summarized in Appendix E.

Client Profile

A total of 32 separate client interviews were conducted. Approximately three-quarters of the clients were female. Only one-quarter reported being newcomers to their community, the largest proportion being relatively long-term residents. Most clients said they sought services for a single problem, although over one-quarter reported multiple problems, normally secondary family-related difficulties stemming from the primary mental health problem of a family member.

The most frequent reason these clients sought services (approximately one-third) was for child behavioral problems and related parent/child or school discipline difficulties. Another quarter sought services for depression, stress, or anxiety, typically related to coping difficulties. Other presenting problems included: psychiatric disorders (4); victims of family violence (3); child emotional disturbances (3); victims of sexual abuse (2); and, marital problems, alcohol abuse, slow learner, brain tumor and family violence offender (1 each).

Service Access

Nearly two-thirds (62%) of clients accessed more than one service, and three-quarters of these accessed three or more services during the course of their treatment. It appears that, in many cases, some of the multiple service providers were involved to conduct assessments for purposes of client referral to a potential treatment service. The involvement of service providers was as follows (percentages do not add to 100 because some clients saw more than one service provider):

- Mental Health 50% of cases interviewed
- Agency Counselling 38% of cases interviewed
- Social Services 34% of cases interviewed
- School Counselling 16% of cases interviewed
- Physician 13% of cases interviewed
- FCSS 9% of cases interviewed
- Women's Shelter 9% of cases interviewed
- Other 34% of cases interviewed

"Other" services included: employment, subsidized housing, addictions, special education, literacy, naturopathy, and probation.

About half (52%) of clients accessed the treatment service through a single referral (including a small number who accessed the service directly without being referred). One-in-eight (13%) received service after two referrals, and one-third (35%) required three or more referrals. It appears that clients either get to the service they need relatively directly (i.e., one referral), or they require many successive referrals (i.e., three or more) until they find a suitable service (or, perhaps, give up trying).

One-third of clients accessed a local service only, one-third external service only, and one-third both a local and external service during the course of treatment. This indicates that fully two-thirds of these clients were required, at some point during their treatment, to travel outside their community to access a service.

It is interesting to note that only one-quarter of clients specifically mentioned that they were required to wait an unacceptable length of time to get into a service to which they were referred. Another quarter did not comment on the issue.

Client Appraisal of Services

A variety of comments were made by clients concerning their experience with the services

received. Table 7 provides a summary of their level of satisfaction with a number of different service aspects.

Competence of service providers appears to be the key concern. Over one-third of clients, whether or not their treatment was deemed successful (see Outcome below), were not satisfied with what they viewed to be the competence of one or more of the service providers they came in contact with during the course of their treatment. Provider attitude was a significant concern for one-third of clients. Generally speaking, clients did not comment about the frequency or duration of the services they received.

Outcome

About one-third (31%) of clients reported unsuccessful treatment outcomes, while one-in-six (16%) reported marginal success, and about one-half (53%) reported successful outcomes to their treatment. Table 8 shows cross tabulations for client outcomes by referral history and agency location. (It should be noted that judgments of outcome are based on client perceptions, not on clinical evidence.)

Of those reporting unsuccessful or marginal outcomes, three-fifths (60%) experienced multiple referrals (i.e., two or more). In contrast, only about one-third (35%) of those reporting a successful outcome experienced multiple referrals. Over half (56%) of those reporting unsuccessful outcomes were referred to an external (out of community) agency only. Those with successful outcomes tended to use local agencies: two-fifths (41%) only local agencies, and two-fifths (41%) local and external agencies. Only one-fifth (18%) of clients reporting a successful outcome used only an agency outside the community.

Table 7

User Satisfaction

Service Satisfaction:	Provider Attitude	Provider Competence	Service Frequency	Service Duration
Unsatisfactory	33%	40%	18%	15%
Satisfactory	39%	50%	3%	—
No Comment	27%	10%	79%	85%

Table 8

Perceived Outcome Success By Referral History and By Location of Service Agency

	Client Outcome		
	Unsuccessful (31%)	Marginal (16%)	Successful (53%)
Referral History:			
Multiple Referral	60%	60%	35%
Single Referral	40%	40%	65%
Total	100%	100%	100%
Agency Location:			
Local Agency Only	33%	17%	41%
External Agency Only	56%	50%	18%
Both	11%	33%	41%
Total	100%	100%	100%

User Comments and Suggestions

Clients were asked what changes they would make to improve the experience of someone in a similar position. A wide range of comments and suggestions were made. These are summarized below:

Services Needed:
- Local counselling services (8)
- Local peer support groups (6)
- Early intervention (3)
- Family counselling (2)
- Activities for singles (1)
- Activities for mothers (1)
- Child behavioral specialists (1)
- Day/child care (1)
- Family respite (1)
- Group therapy (1)
- Information/referral (1)
- Mental health specialists — physicians (1)
- Probation counselling (1)
- Psychiatric services — outpatient group therapy, adolescent (1)
- Prevention programs (1)
- Regional psychiatric services (1)
- Self-help courses (1)
- School counselling — junior high, high (1)
- Teen counselling (1)

Service Access Suggestions:
- Publicize services/resources available (3)
- Promote mental health to reduce stigma (3)
- Educate consumers regarding symptoms (3)
- Home visits
- Cover private psychological services under AHCIP (3)
- Increase funding for staff positions/wages (2)

Staff Competence/Quality:
- Increase professional support for local groups (4)
- Provide more training for medical personnel (3)
- Improve referral/follow-up procedures (1)
- Improve coordination among agencies (1)
- Provide teachers with more mental health training (1)

Other Comments:
- Empower consumers (2)
- Re-evaluate hospital's role in the community (2)
- Provide others in the community with access to company EAPs (1)
- Catalyze community development (1)
- Recruit/train past clients to serve as care givers (1)

Consumers clearly want more local services and better professional support for local service providers. Consumers also want better general publicity of services available, and more promotion of mental health concerns to reduce the stigma and general ignorance of symptoms that prevent people from accessing mental health services.

Survey of Northern Alberta Service Providers

A broadly based survey of mental health services providers in northern Alberta was conducted to further explore service delivery and staffing issues disclosed during community visits and in northern-specific documents reviewed in an earlier section of this report. The objectives of the survey were to identify, by region and by community type, access to mental health services, including perceived service demand and capacity, and to explore employment issues, including staff recruitment and retention issues.

Method

Questionnaires designed to measure the issues raised during the community visits were sent to the district offices of the following agencies and organizations: Alberta Mental Health (AMH; 9 offices); Alberta Alcohol & Drug Abuse Commission (AADAC; 12 offices); Alberta Family & Social Services (AF&SS; 12 offices — sampling about a third of Child Welfare workers); Family & Community Support Services (FCSS; 31 offices); Health Units (9 offices); and a sample of School Divisions having school counsellors that serve residents within NADC boundaries (26 School Divisions). The survey questionnaire is attached as Appendix F.

Office managers were asked to distribute the questionnaires among staff providing mental health services, as broadly defined in this study. These staff were asked to select one of the communities they served and to complete the survey questions relating to mental health service delivery for that community.

Because some of these agencies and organizations have catchment areas that extend beyond NADC boundaries, and because of uncertainty about how many staff employed by health units and school divisions provide services of relevance to this study, the precise sample size of potential respondents could not be calculated. However, of the 243 questionnaires distributed, 130 were returned (53%). Of these 12 were completed for communities not included within NADC boundaries and 10 were returned two or more weeks after the cutoff date, and could not be included in the analysis. Table 9 shows the distribution of the 108 analyzed responses by agency of employment.

These service providers reported on 42 different northern Alberta communities or community groupings. Over 60% of the total population (approximately 254,000 people) residing within NADC boundaries live in these surveyed communities. In addition, many of these communities serve extended catchment areas, increasing the number of northern residents influenced by services delivered in these communities.

The communities represented in the survey have been grouped by region (northeast and northwest)[1] and by community type: *Cities* (Grande Prairie

[1] Northwest and northeast regions of Alberta Mental Health and Alberta Family & Social Services have been used in this study, except where those regions extend south of NADC's boundary. In the northwest region, this extension is minimal; it is more substantial in the northeast region.

Table 9

Survey Respondents by Agency of Employment

Agency (Offices)	Number of Respondents	% of Sample
Alberta Mental Health (9)*	22	20%
Alberta Family & Social Services (12)	22	20%
AADAC (12)	11	10%
FCSS (31)	20	19%
Health Units (9)	17	16%
School Counsellors (26)	13	12%
Other**	3	3%
TOTAL	**108**	**100%**

* Numbers in parentheses are the number of offices receiving questionnaires.
** Two AVC Counsellors and one Indian Band worker not employed by one of the listed agencies.

and Fort McMurray); *Town Service Centres* (Peace River and St. Paul); *Other Towns* (those with populations between 1,000 and 6,600); and *Small Communities* (those with populations of 1,000 or less). Table 10 lists the communities represented in the survey, and the number of respondents reporting on each.

Service Delivery Issues

Included in this section are findings relating to *service access; service demand and capacity*; and *barriers, strengths, and service delivery factors* for communities categorized as Cities, Town Service Centres, Other Towns, and Small Communities in northern Alberta.

Service Access

The survey revealed that access to mental health services is highest in cities and lowest in small communities — those with populations of about 1,000 or less, and which make up nearly half (47%) of the population of northern Alberta.[2] "Access" was defined as the availability of specific mental health services either within the community or within approximately one hour's drive one way.

The percentage of respondents reporting on the accessibility of mental health services in their respective communities is shown graphically in Figures 1 and 2 for Group A and B mental health services, respectively.[3] Specific Group A and B services, along with their percent accessibility scores are shown in Tables 11 and 12, respectively. Because several respondents reported on each City and Town Service Centre, these percentages indicate the proportion of service providers who agree that a specific service is accessible in those communities. For communities categorized as Other Towns and Small Communities, multiple communities are grouped together. In these cases the percentages indicate the proportion of *communities* that have access to a specific service.

For example, 100% of the service providers reported that *child mental health assessment* is available to residents of Grande Prairie (the City in the northwest region; see Table 11), whereas only 82% reported that *counselling for juvenile offenders* is available. Because only one community is involved in this case, the finding that 82% respondents reported that *counselling for juvenile offenders* is available indicates that the availability of this service is less well-known among service providers in that community than some of the other services listed.

The interpretation of the percentages in Tables 11 and 12 is somewhat different for Other Towns and Small Communities. For example, only 50% of respondents reporting on Small Communities in the northwest region (see Table 11) said that *child mental health assessment* is accessible in their respective communities. Although this percentage includes differences in opinion among service providers about the accessibility of that service in communities where multiple service provider reports have been submitted, it also reflects differences in the accessibility of that service among the small communities themselves. Service providers in these communities tend to have a more generalist practice, relative to their counterparts in the cities. Also, fewer workers provide services to each of these communities, and there is less disagreement about service access in these communities. Thus, it is reasonable to conclude that where 50% of service providers reported that a particular service was accessible, that service was accessible to only about 50% of the *communities* reported on. Some variation around this percentage, however, must be allowed to account for differences of opinion among the reporting service providers.

With this caveat in mind, Table 11 indicates that City and Town Service Centre residents have relatively good access to the mental health services listed in Group A. Some differences of opinion do exist, however, about the accessibility of some of these services, particularly among service providers in Peace River and St. Paul (Town Service Centres in the northwest and northeast regions, respectively).

In contrast, many of these services are considerably *less* accessible to residents of Other Towns and Small Communities in the two regions. Group A mental health services to which access is *most limited* are as follows:

[2] Source: *Northern Alberta Today*; 1985; p. 24.

[3] The seventeen services that were assessed in the survey have been divided into two groups for ease of presentation: Groups A and B. This should not be taken to imply that one group of services is more or less important than the other.

Table 10

Communities and the Number of Respondents Reporting on Each

Northwest Region*		Northeast Region*	
Community	**Respondents**	**Community**	**Respondents**
Cities:		**Cities:**	
1. Grande Prairie	14	1. Fort McMurray	4
Town Service Centre:		**Town Service Centre:**	
2. Peace River	10	2. St. Paul	9
Other Towns:		**Other Towns:**	
3. Beaverlodge	2	3. Athabasca	2
4. Fairview	2	4. Bonnyville	4
5. Falher	1	5. Cold Lake	1
6. Fox Creek	1	6. Elk Point	1
7. Grande Cache	3	7. Grand Centre	2
8. High Level	2	8. Lac La Biche	5
9. High Prairie	2	(Subtotal)	(15)
10. Manning	2		
11. Sexsmith	1	**Small Communities:**	
12. Slave Lake	3	9. Boyle	1
13. Smoky River (MD)	1	10. Calling Lake	2
14. Spirit River	2	11. Cold Lake First Nation	1
15. Swan Hills	4	12. Fort Chipewyan	1
16. Valleyview	4	13. Mallaig/Ashmont/ Goodfish Lake	1
17. Whitecourt	6	14. Medley	1
(Subtotal)	(36)	15. Rochester	1
		(Subtotal)	(8)
Small Communities:			
18. Blue Ridge	1	**TOTAL**	**36**
19. Fort Vermilion	2		
20. Hines Creek	1		
21. Hythe	1		
22. La Crete	1		
23. Loon Lake/Red Earth/ Peerless Lake/ Chipewyan Lake	1		
24. Rycroft	1		
25. Silver Valley	1		
26 Wabasca-Desmarais	2		
27. Worsley	1		
(Subtotal)	(12)		
TOTAL	**72**		

* About 60% of residents within NADC boundaries reside in the northwest region. As well, more towns (19 versus 7) and more villages (11 versus 3) are situated in the northwest than in the northeast region (1989 NADC census data). Differences in the number of communities represented in the survey and in the number of service providers responding to the survey for the two regions reflect these facts.

Figure 1

Access to Group A Mental Health Services

Table 11

Percentage of Respondents Reporting Access to Group A Mental Health Services By Community Type

	City	Town Service Centre	Other Towns	Small Communities
Northwest Region:	**(n=14)**	**(n=10)**	**(n=36)**	**(n=12)**
1. Child MH assessment	100	89	90	50
2. Youth/adult MH assessment	100	100	84	55
3. Individual counselling	100	100	94	91
4. Family counselling	100	100	86	60
5. Group counselling	100	89	45	20
6. Counselling/juvenile offenders	82	71	71	40
7. Crisis intervention	100	100	84	73
8. Post-crisis follow-up	90	87	62	73
9. Psychiatrist/other medical backup	100	90	53	58
Weighted Mean*	**97**	**92**	**75**	**58**
Northeast Region:	**(n=4)**	**(n=9)**	**(n=15)**	**(n=8)**
1. Child MH assessment	100	75	50	71
2. Youth/adult MH assessment	100	100	63	71
3. Individual counselling	100	100	80	71
4. Family counselling	100	87	77	57
5. Group counselling	100	80	50	43
6. Counselling/juvenile offenders	100	43	58	50
7. Crisis intervention	75	100	79	100
8. Post-crisis follow-up	100	71	75	50
9. Psychiatrist/other medical backup	100	78	71	57
Weighted Mean*	**95**	**83**	**68**	**62**

* "Don't Know" responses were highest in Cities and Town Service Centres (ranging from 0% to 37%) and lowest in the Small Communities (ranging from 0% to 10%).

Figure 2

Access to Group B Mental Health Services

Table 12

Percentage of Respondents Reporting Access to Group B Mental Health Services By Community Type

	City	Town Service Centre	Other Towns	Small Communities
Northwest Region:	**(n=14)**	**(n=10)**	**(n=36)**	**(n=12)**
1. School counselling	100	100	97	87
2. School liaison program	100	100	77	90
3. Parenting/discipline program	63	71	57	70
4. Pastoral counselling	100	100	100	86
5. Women's shelter	100	22	76	50
6. Post-shelter follow-up	87	50	48	60
7. Substance abuse self-help group	100	73	97	67
8. Substance abuse treatment	92	100	77	60
Weighted Mean*	**95**	**77**	**78**	**70**
Northeast Region:	**(n=4)**	**(n=9)**	**(n=15)**	**(n=8)**
1. School counselling	100	100	100	60
2. School liaison program	100	80	92	50
3. Parenting/discipline program	100	60	86	29
4. Pastoral counselling	67	75	100	50
5. Women's shelter	100	89	62	29
6. Post-shelter follow-up	100	60	46	33
7. Substance abuse self-help group	100	100	100	80
8. Substance abuse treatment	100	78	93	29
Weighted Mean*	**96**	**82**	**84**	**57**

* "Don't Know" responses were highest in Cities and Town Service Centres (ranging from 0% to 43%) and lowest in the Small Communities (ranging from 0% to 33%).

Northwest Region

- *group counselling* (Small Communities — 20%; Other Towns — 45%)
- *counselling for juvenile offenders* (Small Communities — 40%)
- *child mental health assessment* (Small Communities — 50%)
- *psychiatrist and other medical backup* (Other Towns — 53%; Small Communities — 58%)
- *youth/adult mental health assessment* (Small Communities — 55%)
- *family counselling* (Small Communities — 60%)
- *post-crisis follow-up* (Other Towns — 62%).

Northeast Region

- *group counselling* (Small Communities — 43%; Other Towns — 50%)
- *counselling for juvenile offenders* (Small Communities — 50%; Other Towns — 58%)
- *child mental health assessment* (Other Towns — 50%)
- *post-crisis follow-up* (Small Communities — 50%)
- *psychiatrist and other medical backup* (Small Communities — 57%)
- *family counselling* (Small Communities — 57%)
- *youth/adult mental health assessment* (Other Towns — 63%).

Figure 2 shows that the pattern for mental health services listed in Group B (see Table 12) is similar to that for Group A services, with the exception that access to Group B services in Town Service Centres is similar to that found in Other Towns (see Figure 2 and Table 12). Group B mental health services to which access is *most limited* are as follows:

Northwest Region

- *women's shelter* (Town Service Centre — 22%; Small Communities — 50%)
- *post-shelter follow-up* (Other Towns — 48%; Town Service Centres — 50%; Small Communities — 60%)
- *parenting/discipline program* (Other Towns — 57%; City — 63%)
- *substance abuse treatment* (Small Communities — 60%).

Northeast Region

- *women's shelter* (Small Communities — 29%; Other Towns — 62%)
- *parenting/discipline program* (Small Communities — 29%; Town Service Centre — 60%)
- *substance abuse treatment* (Small Communities — 29%)
- *post-shelter follow-up* (Small Communities — 33%; Other Towns — 46%; Town Service Centres — 60%)
- *pastoral counselling* (Small Communities — 50%)
- *school liaison program* (Small Communities — 50%)
- *school counselling* (Small Communities — 60%).

Several communities included in the survey are composed primarily of native residents: Calling Lake, Cold Lake First Nation, Loon Lake, Red Earth, Peerless Lake, Chipewyan Lake, Goodfish Lake, Fort Chipewyan, Wabasca-Desmarais. Service providers in these communities (which are also included in the access data presented above for Small Communities),[4] report a service access pattern that is much like that for Small Communities in general. Weighted mean accessibility scores for Group A and B mental health services for these predominantly native communities are 59% and 50%, respectively. Specific services for which access in these native communities is *most limited* are as follows:

Group A Mental Health Services:

- *group counselling* (37%)
- *counselling for juvenile offenders* (43%)
- *family counselling* (50%)
- *psychiatrist and other medical backup* (50%)

[4] Three out of twelve respondents who reported on Small Communities in the northwest region reported on native communities. In the northeast region this figure was five out of eight.

- *child mental health assessment* (62%)
- *youth/adult mental health assessment* (62%).

Group B Mental Health Services:

- *substance abuse treatment* (25%)
- *parenting/discipline program* (43%)
- *pastoral counselling* (50%)
- *post-shelter follow-up* (57%)
- *school counselling* (60%).

In summary, these findings clearly indicate that residents living *outside* the cities of Grande Prairie and Fort McMurray, and to a somewhat lesser extent, the Town Service Centres of Peace River and St. Paul, have considerably *less* access to mental health services than those living in these four communities. Moreover, access to services is most limited in the Smaller Communities, including native communities, where almost half of the population of northern Alberta resides. This general pattern is exacerbated by the fact that some services are accessible only to certain residents within these communities (for example, in communities where *child mental health assessment* is restricted to Child Welfare cases only). Further information about restricted services as well as data relating to service responsiveness is provided in Appendix G.

A corollary to this finding is that access to specific services varies considerably from community to community. In general, variability of access is greatest for those services that are least available to residents living in communities categorized as Other Towns and Small Communities.

Of the 17 mental health services assessed, *individual counselling*, *crisis intervention* and *substance abuse self-help groups* are the only services generally accessible to northern residents regardless of the type of community in which they reside.

Service Demand and Capacity

The bar graphs in Figure 3 show that the amount of demand placed on mental health services as a result of social, psychological, child/parenting, or other problems is roughly equivalent across community type (Cities, Town Service Centres, Other Towns, Small Communities). A rating of "1" indicates that demand is "very low", whereas a rating of "7" indicates that demand is "very high".

Perceived demand on services stemming from *mental handicaps* and *cognitive dysfunctions in the elderly* ("Other Problems" in Figure 3) is lowest, relative to problem areas categorized as social, psychological, and child/parenting.

Table 13 shows the mean demand scores by community type in the northwest and northeast regions for each source of problem. Overall, perceived demand was found to be roughly similar in the northwest and northeast regions, with the following exceptions:

- *Mental handicaps* and *cognitive dysfunctions in the elderly* ("Other Problems") were perceived to be placing greater demand on mental health services in the northeast than in the northwest region for communities categorized as the Town Service Centre, Other Towns, and, to a lesser extent, Small Communities.
- Perceived demand stemming from social problems was seen to be higher in the northeast than in the northwest region for communities categorized as Town Service Centres (St. Paul and Peace River, respectively).

The line graphs superimposed on the bar graphs in Figure 3 show that northern communities have a very limited capacity to deal effectively with these problem areas. A rating of "1" indicates "very inadequate capacity" to deal with the problem, whereas a rating of "7" indicates "adequate capacity" only.

Similar to findings about access presented in the last section, perceived capacity to deal effectively with each problem area, except child/parenting problems, decreases as the size of the community decreases.

Perceived capacity to deal effectively with these problems is roughly similar for communities in the northwest and northeast regions (see Table 14). The principal exception to this is that the city of Grande Prairie in the northwest region was rated as having a lower capacity to deal with these problems than the city of Fort McMurray in the northeast region.

In summary, demand is seen to be fairly high for most problem areas regardless of community type. Perceived capacity to deal effectively with the demand, however, is quite limited, and it decreases as community size decreases.

Figure 3

Perceived Demand Placed on Mental Health Services and the Capacity to Deal Effectively with it By Problem Type

Demand Scale: 1-7 (1 = "Very Low Demand" and 7 = "Very High Demand")
Capacity Scale: 1-7 (1 = "Very Inadequate Capacity" and 7 = "Adequate Capacity")

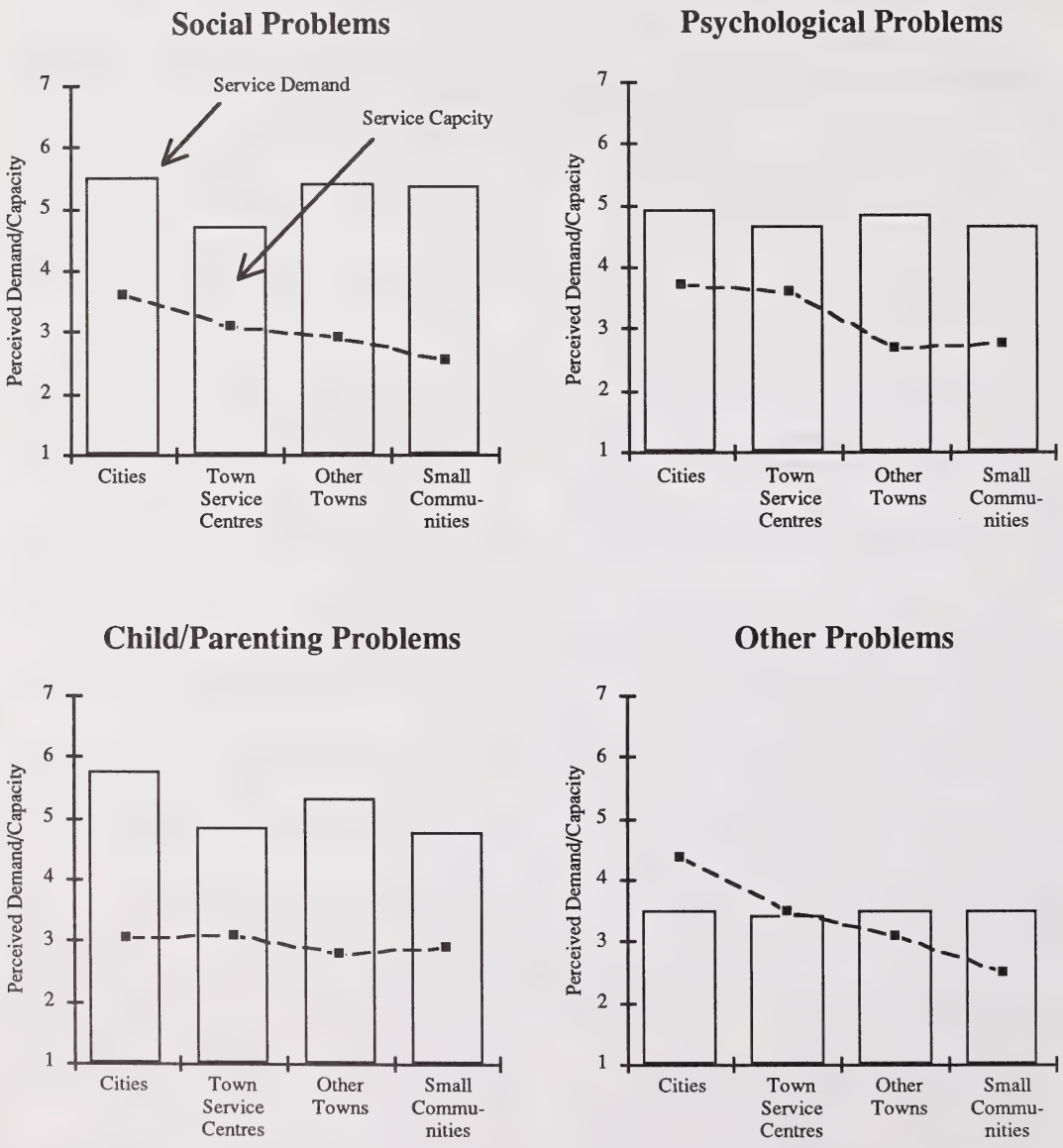


Table 13
Mean Perceived *Demand* for Services By Community Type

(Scale from 1-7, where 1 equals "Very Low Demand" and 7 equals "Very High Demand")

	City	Town Service Centre	Other Towns	Small Communities
Northwest Region:	**(n=14)**	**(n=10)**	**(n=36)**	**(n=12)**
Social Problems				
1. Substance abuse among youth	4.9	3.6	5.1	5.6
2. Substance abuse among adults	5.5	4.0	5.5	5.2
3. Child abuse	5.5	4.3	5.0	4.8
4. Sexual abuse	5.9	4.6	5.1	4.9
5. Battering	5.5	4.2	5.7	5.8
6. Marital discord	5.8	4.5	5.6	5.4
Mean	**5.6**	**4.1**	**5.3**	**5.3**
Psychological Problems				
1. Depression/anxiety	5.9	5.6	5.6	5.6
2. Major emotional problems	5.2	4.5	4.8	4.6
3. Suicidal behavior	5.8	5.1	5.1	4.9
4. Sexual dysfunction	3.8	3.1	3.4	3.2
Mean	**5.1**	**4.3**	**4.7**	**4.6**
Child/Parenting Problems				
1. Behavioral problems among children	5.6	5.0	5.3	4.5
2. Parenting/discipline problems	6.2	4.5	5.5	4.5
Mean	**6.0**	**4.7**	**5.3**	**4.6**
Other				
1. Mental handicaps	3.4	3.2	2.7	2.9
2. Cognitive dysfunctions in the elderly	3.9	2.8	3.5	3.5
Mean	**3.6**	**2.9**	**3.1**	**3.2**
Northeast Region:	**(n=4)**	**(n=9)**	**(n=15)**	**(n=8)**
Social Problems				
1. Substance abuse among youth	4.8	5.3	5.5	6.0
2. Substance abuse among adults	5.7	5.2	5.4	5.3
3. Child abuse	4.0	5.9	5.4	4.5
4. Sexual abuse	4.5	6.0	5.3	4.8
5. Battering	5.7	5.3	5.4	5.2
6. Marital discord	5.0	5.4	5.4	5.5
Mean	**5.0**	**5.5**	**5.5**	**5.2**
Psychological Problems				
1. Depression/anxiety	4.7	5.6	5.1	5.3
2. Major emotional problems	4.3	5.2	5.1	4.7
3. Suicidal behavior	4.8	5.2	5.3	4.3
4. Sexual dysfunction	3.7	3.9	3.9	4.3
Mean	**4.3**	**4.9**	**4.9**	**4.7**
Child/Parenting Problems				
1. Behavioral problems among children	4.7	5.1	5.5	5.5
2. Parenting/discipline problems	5.3	5.1	5.2	5.2
Mean	**5.0**	**5.1**	**5.4**	**5.3**
Other				
1. Mental handicaps	3.3	3.6	4.6	3.7
2. Cognitive dysfunctions in the elderly	3.3	4.4	4.1	4.2
Mean	**3.3**	**4.0**	**4.5**	**3.9**

Table 14

Mean Perceived *Capacity* for Services By Community Type

(Scale from 1-7, where 1 equals "Very Inadequate Capacity" and 7 equals "Adequate Capacity")

	City	Town Service Centre	Other Towns	Small Communities
Northwest Region:	**(n=14)**	**(n=10)**	**(n=36)**	**(n=12)**
Social Problems				
1. Substance abuse among youth	3.3	3.1	2.9	2.4
2. Substance abuse among adults	4.1	3.1	3.2	2.4
3. Child abuse	2.7	2.8	2.8	2.3
4. Sexual abuse	3.4	3.2	2.5	2.4
5. Battering	3.6	2.6	2.8	2.3
6. Marital discord	2.9	3.5	2.5	2.6
Mean	**3.4**	**2.9**	**2.8**	**2.4**
Psychological Problems				
1. Depression/anxiety	3.6	4.3	2.8	2.7
2. Major emotional problems	3.4	3.7	2.5	2.5
3. Suicidal behavior	3.5	3.6	2.9	3.3
4. Sexual dysfunction	2.3	2.4	2.0	2.0
Mean	**3.4**	**3.4**	**2.7**	**2.6**
Child/Parenting Problems				
1. Behavioral problems among children	2.7	2.8	2.8	3.2
2. Parenting/discipline problems	2.3	3.0	2.6	3.1
Mean	**2.5**	**3.0**	**2.7**	**3.1**
Other				
1. Mental handicaps	3.9	3.3	3.1	2.5
2. Cognitive dysfunctions in the elderly	4.7	2.4	2.9	2.7
Mean	**4.3**	**2.8**	**3.1**	**2.6**
Northeast Region:	**(n=4)**	**(n=9)**	**(n=15)**	**(n=8)**
Social Problems				
1. Substance abuse among youth	3.8	3.2	3.3	1.8
2. Substance abuse among adults	4.7	3.7	3.6	2.8
3. Child abuse	3.2	2.9	2.9	2.0
4. Sexual abuse	4.3	2.4	2.1	1.8
5. Battering	4.7	3.6	2.5	2.3
6. Marital discord	5.0	2.3	2.7	2.5
Mean	**4.5**	**3.0**	**2.8**	**2.4**
Psychological Problems				
1. Depression/anxiety	4.0	4.0	2.6	2.8
2. Major emotional problems	3.8	3.9	2.2	2.5
3. Suicidal behavior	3.5	4.4	2.7	3.0
4. Sexual dysfunction	4.7	2.7	2.7	2.0
Mean	**4.4**	**3.7**	**2.5**	**2.7**
Child/Parenting Problems				
1. Behavioral problems among children	4.0	3.2	2.5	2.5
2. Parenting/discipline problems	4.7	3.2	3.1	2.7
Mean	**4.7**	**3.2**	**2.9**	**2.6**
Other				
1. Mental handicaps	3.3	3.9	2.2	1.7
2. Cognitive dysfunctions in the elderly	4.3	4.2	3.4	2.2
Mean	**3.8**	**4.0**	**2.9**	**2.1**

Barriers, Strengths, and Service Delivery Factors

Tables 15 and 16 list the barriers to providing optimal mental health services in communities in the northwest and northeast regions, respectively. Inadequate resources, client impediments (stigma around mental health, lack of anonymity, distances to services, etc.), problems with service coordination, and staffing issues are commonly cited as barriers, regardless of community type or region. Socio-cultural issues are cited most frequently by respondents providing services to Other Towns and Small Communities in the northwest, and to the Town Service Centre and Small Communities in the northeast. Lack of staff and/or professional support is not cited as a barrier in the Cities, but is cited as a barrier in most of the other communities.

Tables 17 and 18 list the strengths or resources that could be used to overcome or compensate for these barriers. The strengths cited revolve mostly around the high quality of the staff, good cooperation and networking among staff, the responsiveness and support of the communities, and specific organizations and agencies. In many cases, these are the inverse of some of the issues that were cited as barriers.

Typically, these inverse relationships are cited as either barriers or strengths in different communities (for example, where good coordination and networking among staff is absent, it is seen as a barrier; and where it is present, it is seen as a strength). In other cases, some of the strengths are seen as resources that could *potentially* be used to reduce some of the barriers experienced by service providers were they more effectively exploited.

Figure 4 shows how important the service providers think certain changes to service delivery would be in reducing the problems they are encountering. Although all of the changes listed are seen as important, some are thought to be more important than others, depending on the type of community under consideration. *Greater availability of professional service providers* received the highest rating by those reporting on the Cities, whereas *more non-professional care-givers* received the lowest rating. In contrast, those responding on Town Service Centres, Other Towns, and Small Communities rated *greater availability of professional service providers* among the lowest, and *more non-professional care-givers* highest.

Figure 5 shows how important the service providers think certain socio-economic factors are in relation to mental health problems. Although some variability in the importance of these factors is evident among community types, *reduced employment opportunities* is the only factor that received markedly different ratings. This factor is rated highest by those reporting on Small Communities, and lowest by those reporting on Cities, Town Service Centres, and Other Towns.

In summary, a variety of barriers to providing optimal mental health services in northern Alberta were identified, as were community strengths or resources that could be used to reduce these barriers. (These barriers and strengths were similar to those mentioned in the section of this report entitled Community Visits.) The changes to service delivery that respondents reporting on Cities thought would be most important for reducing service delivery problems differed from those reporting on Town Service Centres, Other Towns, and Small Communities. Those responding on Cities thought that *greater availability of professional service providers* would be most important and that *more non-professional care-givers* would be least important. The importance of these changes was reversed for those responding on Town Service Centres, Other Towns, and Small Communities.

Employment-Related Issues

Table 19 presents employment-related findings grouped by the respondent's place of employment. Overall, survey respondents provided health and/or social services to their communities for a median of 3.2 years (i.e., half provided services for less than 3.2 years and half for more than 3.2 years).[5] This median figure was not notably different for those serving communities in the northwest versus the northeast region (3.0 versus 3.4 years, respectively).

Median years of service, however, did differ markedly between regions for those employed by Alberta Mental Health (AMH), with workers in the northwest serving a median of eight years,

[5] Because these data do not include 100% of the workers in any one employment group, and because some positions are unfilled, especially AMH positions, these data cannot be directly interpreted as retention statistics. Rather, they can only be viewed as *indicators* of retention, at best.

Table 15

Conditions or Attributes Acting As Barriers to the Provision of Optimal Mental Health Services Northwest Region

City

1. Lack of access to appropriate services
2. High demand, low resources
3. Inadequate and inaccessible resources
4. Inadequate professional resources in child psychology
5. Inadequate information sharing among professionals
6. Long waiting lists
7. Lack of prevention and early intervention programs

Town Service Centre

8. Lack of resident psychiatrist
9. Underfunded agencies
10. Lack of appreciation and recognition of mental health services
11. Stigma associated with the need for mental health services
12. Political indifference
13. Misunderstanding of mental health services
14. Lack of specialized services
15. High staff turnover

Other Towns

16. Lack of professional resources
17. Inadequate resources to cope with the demand
18. Work loads too high
19. Distance to some services; most services out of town
20. Lack of community-based professionals
21. Lack of anonymity
22. Lack of confidentiality, trust
23. Lack of continuity among staff
24. Limited networking among service providers; also in service coordination
25. Lack of co-worker support
26. Too much protection of turf by agencies
27. Lack of coordination of mental health workers with other professionals in the community
28. Lack of support from local government
29. Older farm families
30. Stigma around mental health issues
31. Jurisdictional problems

Small Communities

32. Size of community
33. Location, distance to services
34. Discrimination, prejudice re mental health issues
35. Conservative religious beliefs
36. Cultural attitudes
37. Lack of professional support
38. Inappropriate funding of local and regional programs
39. Waiting periods

Table 16

Conditions or Attributes Acting As Barriers to the Provision of Optimal Mental Health Services Northeast Region

City

1. Stigma associated with mental health issues
2. Staff turnover
3. Family breakups
4. Lack of anonymity
5. Budget restrictions
6. Inadequate professional staff resources

Town Service Centre

7. Local, traditional cultures
8. Native versus non-native cultures; also French culture
9. Difficult to treat natives
10. Lack of general family counselling
11. Transient professionals
12. Lack of staff continuity
13. Professional conflicts
14. Inadequate staff support
15. Bureaucratic interference
16. Distance

Other Towns

17. Distance to services in the City
18. Unattractiveness of mental health job
19. Staff shortages
20. Excessive work load
21. Over-prescribing by local MDs
22. Lack of professional educational opportunities
23. Community denial of mental health issues
24. Untrained staff; and lack of professional support
25. Inadequate information sharing among service providers
26. Lack of cooperation among staff
27. Professional burnout
28. Work overload

Small Communities

29. Ethnic, cultural barriers
30. Denial of need for services
31. Native men resist services
32. Lack of anonymity
33. Lack of local leadership
34. Lack of trained professionals
35. Distance to most services
36. Inadequate use of existing services

Table 17

Community Strengths or Resources that Could Be Used to Overcome or Compensate for Barriers to the Provision of Optimal Mental Health Services Northwest Region

City

1. Excellent networking
2. High morale among Alberta Mental Health staff
3. Good cooperation among professionals
4. Professionals caring about other professionals
5. The Spectrum initiative
6. Good community strength
7. Local self-help groups
8. High level of volunteerism
9. Room to develop, expand service delivery

Town Service Centre

10. The people themselves
11. Accessibility of local MDs
12. Interagency cooperation
13. Good hospital/Mental Health relations
14. Community outreach services
15. Good employment opportunities

Other Towns

16. Community's lobbying ability
17. Community's strong sense of self-responsibility
18. Strong community values
19. Open-mindedness of community
20. High level of community volunteers
21. High education level of local population
22. Interagency group
23. FCSS activities, programs and staff
24. Hospital staff
25. South Peace Health Unit
26. Willingness to share among agencies, staff
27. Shared training opportunities
28. Ability to use time effectively
29. Self-help groups
30. Family and other support networks

Small Communities

31. School
32. Good inter-agency communications
33. Professional freedom
34. Influence of pastors
35. Strong professional support
36. Local Health Unit
37. Close-knit community
38. Good community support
39. Good local resource people
40. Size of community
41. Plentiful volunteers

Table 18

Community Strengths or Resources that Could Be Used to Overcome or Compensate for Barriers to the Provision of Optimal Mental Health Services Northeast Region

City

1. Good busing to town
2. Close-knit community
3. Interagency cooperation
4. Continuous learning and sharing of ideas
5. Availability of local training

Town Service Centre

6. Interagency coordination
7. Support and accessibility of the media
8. Insight program
9. Good community interest
10. FCSS
11. Good cooperation from schools
12. Sharing among professionals
13. Community-based psychiatric in-patient service
14. Strong informal support structure

Other Towns

15. Interagency coordination
16. FCSS
17. Agency support
18. Lakeland College
19. AVC
20. Trained paraprofessionals
21. Active social lives
22. Local advocacy groups
23. Community attitude
24. Community support

Small Communities

25. Sexual abuse prevention team
26. Lay counselling
27. The people
28. Crisis centre
29. Native addiction workers

Figure 4

Importance of Changes for Reducing Mental Health Service Delivery Problems

Scale: 1-7 (1 = "Not Important" and 7 = "Very Important")

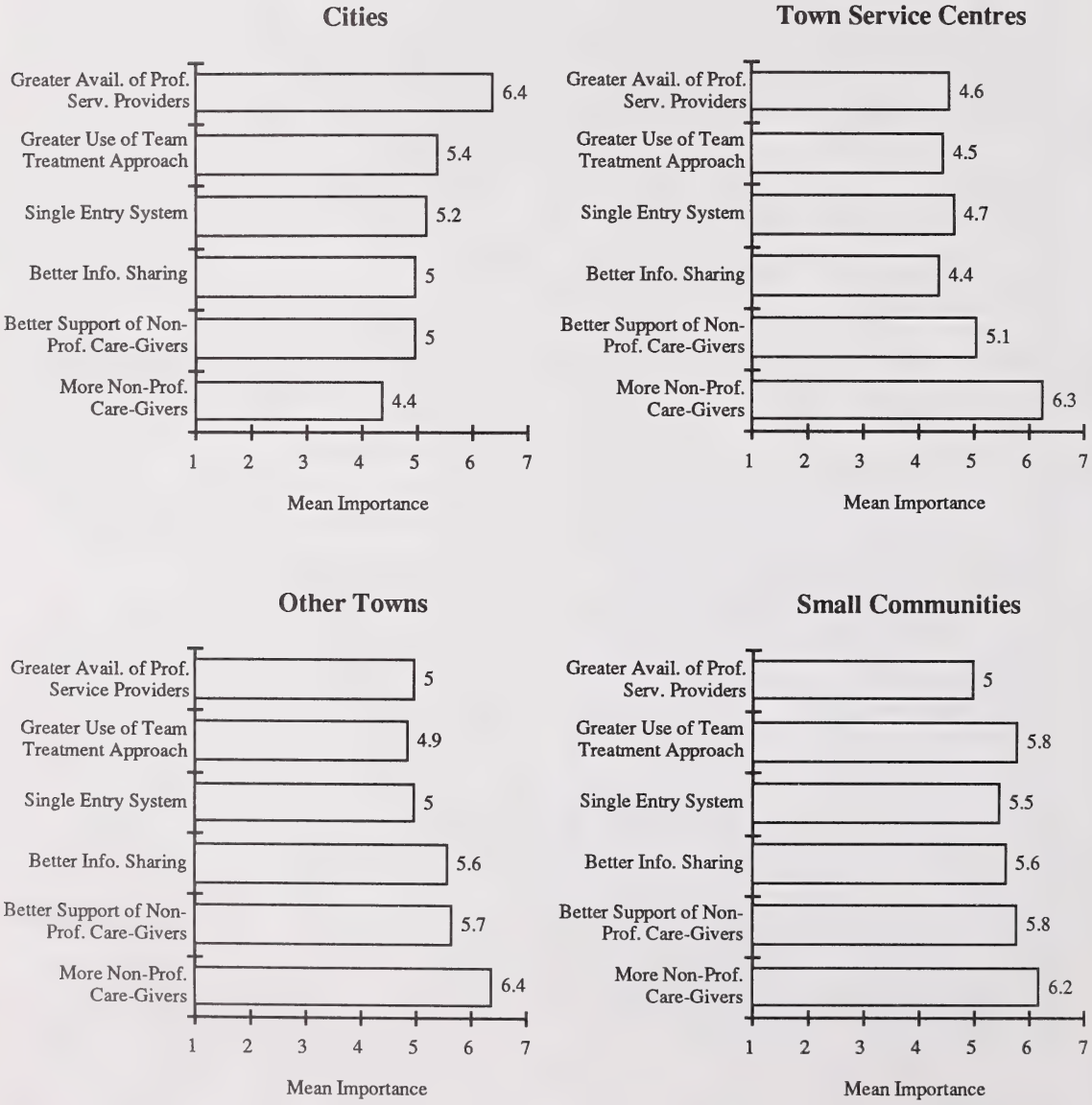


Figure 5

Importance of Socio-Economic Factors in Relation to Mental Health Problems

Scale: 1-7 (1 = "Not Important" and 7 = "Very Important")

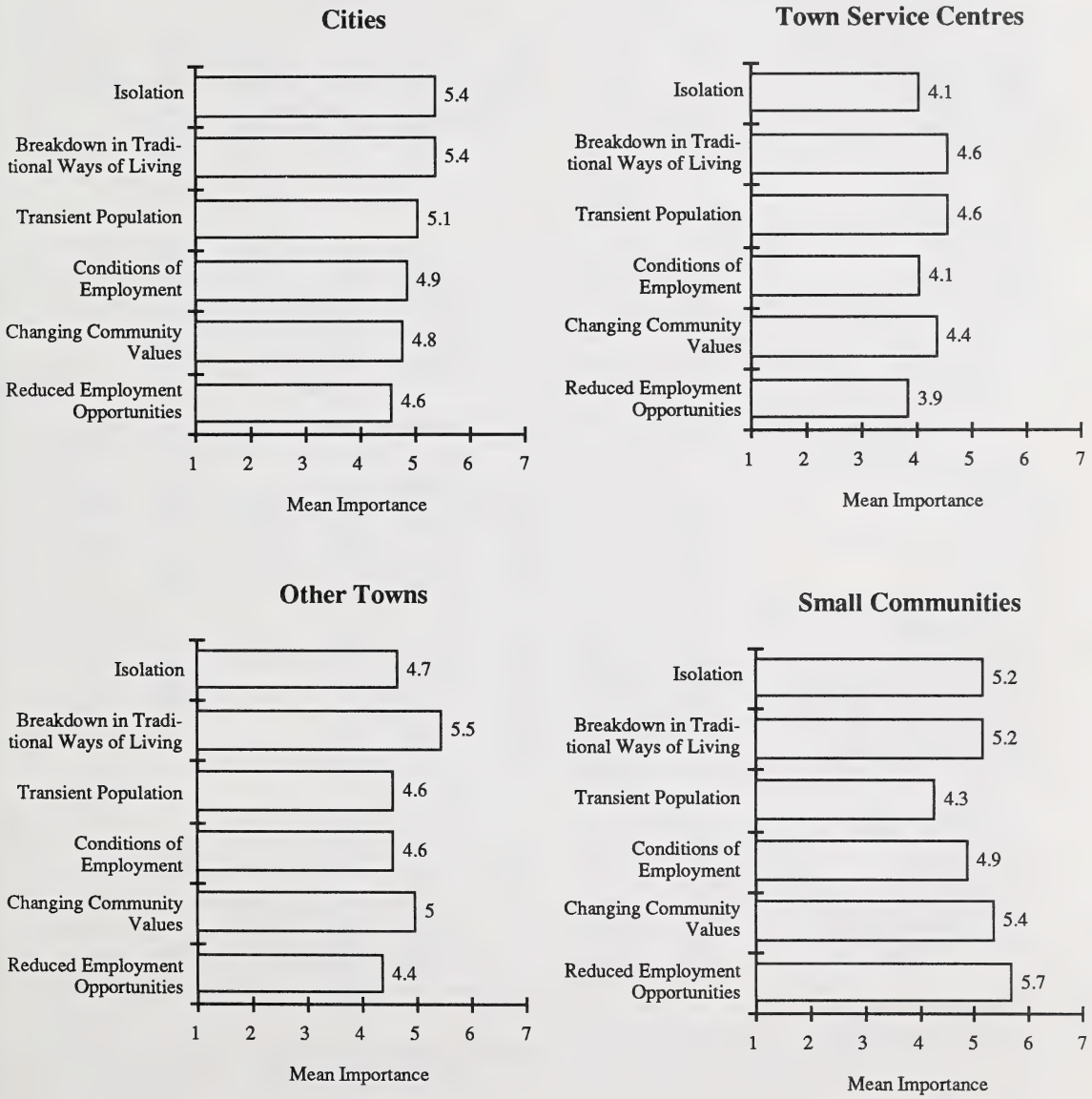


Table 19

Employment Related Issues By Respondent's Place of Employment

ISSUE:	Total (n=108)	AMH (n=22)	AF&SS[1] (n=22)	AADAC (n=11)	FCSS (n=20)	H. U. (n=17)	S. B.[2] (n=13)	Other (n=3)
1. Years Serving Community:								
- Median years: Total	3.2	6.0	2.0	4.0	2.0	10.0	2.0	7.0
- Median years by Region: NW/NE	3.0/3.4	8/1	2/3	2.5/5	2/2.5	10/9	1.5/10	—
2. Prior Residence:								
(a) Edmonton/Calgary	27%	30%	50%	18%	15%	18%	18%	25%
(b) Out of province	22%	25%	18%	18%	20%	24%	35%	—
(c) This community	22%	25%	14%	27%	25%	23%	9%	25%
(d) Other northern rural com.	17%	10%	18%	18%	30%	12%	18%	—
(e) Other northern urban com.	6%	10%	—	9%	—	12%	9%	—
(f) Southern Alta. rural com.	4%	—	—	—	5%	6%	9%	25%
(g) Other southern Alta. urban com.	3%	—	—	9%	5%	6%	—	—
3. Important Reasons for Taking Position:[3]								
(a) The job itself	68%	70%	68%	64%	70%	71%	67%	75%
(b) Experience	37%	60%	50%	36%	35%	12%	25%	33%
(c) Professional advancement	22%	30%	18%	18%	25%	18%	33%	—
(d) To work in the north	19%	10%	27%	27%	15%	17%	25%	33%
(e) Spouse was transferred	19%	25%	14%	9%	30%	35%	—	—
(f) The pay	11%	20%	9%	—	15%	12%	8%	—
(g) I was transferred	2%	5%	—	9%	—	—	—	—
4. Sufficiently Trained to Work in the North? .... "YES"	71%	45%	62%	100%	84%	71%	82%	100%
5. Expected Length of Stay in Current Position in the North:								
(a) No plans to leave	38%	21%	18%	54%	35%	53%	55%	75%
(b) More than 5 yrs.	13%	5%	9%	27%	30%	12%	—	—
(c) 2-5 yrs.	27%	47%	41%	—	30%	23%	—	25%
(d) 1-2 yrs.	14%	21%	14%	9%	5%	12%	27%	—
(e) Less than 1 yr.	8%	5%	18%	9%	—	—	18%	—
6. Reason, if Leaving in 2 Years:[3]								
(a) Burned out	20%	5%	50%	—	20%	12%	25%	—
(b) Better education opportunities	16%	25%	27%	27%	5%	6%	8%	—
(c) Professional advancement	15%	20%	23%	18%	10%	—	25%	—
(d) Work/live in larger community	11%	10%	18%	—	5%	12%	25%	—
(e) Spouse is being transferred	10%	20%	5%	—	20%	6%	—	—
(f) Better working conditions	9%	5%	36%	—	5%	—	—	—
(g) Better pay	8%	15%	4%	—	15%	—	8%	—
7. Inducement to Stay, if Leaving in 2 Years:[3]								
(a) Reduced work load	25%	20%	55%	18%	15%	6%	25%	33%
(b) Better pay	22%	45%	18%	—	30%	6%	25%	—
(c) More time to work with others in the com. on mental health issues	21%	30%	41%	18%	5%	12%	8%	33%
(d) Better advancement opportunities	17%	25%	18%	9%	20%	12%	17%	—
(e) Better prof./collegial support	11%	10%	9%	9%	15%	12%	17%	—
(f) Nothing	5%	—	9%	9%	5%	6%	—	—

[1] Child Welfare workers only.
[2] School counsellors.
[3] Respondents could select up to three alternatives; thus, percentages do not add to 100.

compared to a median of only one year for those in the northeast region. Counsellors employed by school boards and by AADAC also showed marked regional differences, though in the opposite direction (median years of service for counsellors employed by AADAC and school boards in the northwest were 1.5 and 2.5, respectively, compared to 10 and 5 years, respectively, in the northeast). Responses to the questions "Reason for leaving, if leaving in 2 years" and "What would induce you to stay, if leaving within 2 years?" (see #6 and #7 in Table 19) failed to reveal any notable regional differences among these workers.

The following are highlights of other employment-related findings shown in Table 19:

- A third to over half of the respondents in each employment group either lived in the community in which they were currently working or in another northern rural or urban community just prior to taking their current position (alternatives c, d and e for #2 in Table 19).
- Sixty percent of AMH workers and 50% of AF&SS workers said they took their current positions for *the job itself*; this percentage was lower for other workers. In contrast, only 10% of AMH workers said they took their current position in order to *work in the north*; this percentage was higher for other workers.
- Forty-five percent of AMH workers thought they were *sufficiently trained to work in the north*, compared to between 62% and 100% for other workers.
- Forty-five percent of counsellors with school boards said they only plan to stay in their current position in the north for two years or less. Employers with the next highest percentage of workers who only plan to stay for two years or less were AF&SS (Child Welfare workers; 32%) and AMH workers (26%). In contrast, 95% of FCSS workers plan to stay in their current position in the north for more than two years.
- For those planning to leave their current position in the north within two years, *burnout* was cited as a major reason by 50% of the AF&SS (Child Welfare) workers. In contrast, only 5% of AMH workers selected this reason. *Better education opportunities* and *professional advancement* were common reasons for AMH, as well as AF&SS and AADAC workers.
- For AMH workers planning to leave their current position in the north within two years, *better pay, more time to work with others in the community on mental health issues,* and *better advancement opportunities* were changes that would most influence them to stay. For AF&SS (Child Welfare) workers, the most common changes cited were *reduced workload* and *more time to work with others in the community on mental health issues.* (No notable regional differences in these response patterns were found.)

Respondents rank-ordered five recruitment and six retention strategies in terms of the importance of each strategy for improving the quantity of qualified staff working in the north. *Better pay* was ranked highest as a recruitment strategy (mean ranking of 2.18),[6] followed by *the inclusion of northern rural practice course work during training* (2.88), *better information about the quality of life available in the north* (3.00), and *availability of northern practicum opportunities during training* (3.06). *More aggressive recruitment practises, e.g., recruiting in other provinces and in other countries* was ranked lowest (3.68).

The top ranked retention strategies were*: a reduced client load so that workers can develop services and activities tailored to their community* (2.88), and *better pay* (2.89). *Better opportunities for educational upgrading* received the next highest ranking (3.36), followed by *better professional/collegial support* (3.73) and *better opportunities for professional advancement* (3.75). *Providing professional staff with non-professional subordinates to assist with preventive health promotion, follow-up, and group work within the community* was ranked lowest (4.09). Other recruitment and retention strategies suggested by respondents are presented in Table 20.

In summary, the number of years (a median of 3.2) that respondents provided services to communities in northern Alberta was relatively high. This suggests that these respondents have a good deal of experience with the issues that were the focus of this survey. There were, however, some re-

[6] The lower the mean ranking the more importantly respondents viewed the strategy.

gional differences: AMH workers in the northeast reported substantially fewer years of service than those in the northwest, whereas school counsellors and AADAC workers in the northwest reported substantially fewer years of service than those in the northeast.

The reasons respondents cited for taking their current positions, and for leaving them (for those planning to leave within the next two years), as well as whether or not they thought they were sufficiently trained to work in the north, differed depending on the agency of employment. Recruitment strategies given the highest ranking were: *better pay* and *the inclusion of northern rural practice course work*. Retention strategies given the highest ranking were: *a reduced client load so that workers can develop services and activities tailored to their community*, and *better pay*.

Table 20

Other Recruitment and Retention Suggestions

Recruitment Suggestions

Training and Staffing

1. Train more northerners and more natives.
2. Recruit more local, nearly qualified staff and provide upgrading.
3. More bursaries for northern residents to get training.
4. Provide incentives for trained northerners to return to the north.
5. Increase the number of staff in permanent positions.
6. Increase the number of northern educational institutions.

Financial

7. Provide housing and moving incentives.
8. Develop more creative benefits packages.
9. Provide sabbatical opportunities for northern practitioners.

Other

10. Design more attractive jobs.
11. Promote northern living better.
12. Develop a good pre-employment orientation program.
13. Provide spousal employment opportunities.

Retention Suggestions

Professional Development

1. Provide more professional development opportunities; PD budget should be 5 times that of city.
2. Provide educational leave for graduate school.
3. Provide more inservice opportunities.
4. More opportunities for staff to advance without having to go to the cities.

Professional Support

5. Provide more support for northern practitioners.
6. Provide better opportunities to network with others and with specialists.

Financial

7. Develop special pay increments for those who stay in the north.
8. Provide a long-term service increment.

Other

9. Focus on family issues; e.g., education, employment.
10. Develop ways to reduce burnout.
11. Provide extended holidays for northern practitioners.
12. Provide flexible hours and relief staff.
13. Develop more realistic work loads.

Summary of Findings: Themes and Patterns

Principal Conclusions

Three principal conclusions emerge from the data gathering components of this study:

1. Current service delivery systems are falling short of meeting the mental health needs of many northern residents.
2. Service deficiencies are most severe for northern Albertans living in towns and smaller communities outside Fort McMurray and Grande Prairie and, to a lesser extent, outside the service centres of Peace River and St. Paul — with deficiencies being more pronounced as community size decreases and remoteness increases.
3. Service delivery issues vary considerably from community to community.

Through their participation in this study and previous projects, northern Alberta residents and service providers have identified numerous obstacles and resources related to mental health services in their communities. The following discussion serves to clarify patterns, to synthesize the wealth of data into an understandable framework that allows for consideration of specific strategies.

Though not specifically solicited, a number of individuals and organizations have submitted written briefs that have contributed to this study. A list of these is attached as Appendix H.

Impediments to Service Delivery

Figure 6 on the following page provides an overview of the range of impediments that were identified during the course of this study. These have been segregated into two major categories:

- conditions that impede *clients* from accessing services available to them (user perspective)
- conditions that impede *agencies, communities* and *workers* trying to deliver adequate and appropriate services (provider perspective).

Client Impediments

Northern residents reported a variety of factors inhibiting their access to services. These were:

- *Lack of Awareness* — Residents do not always know that services are available and that they have the right to use them. Many also do not recognize the symptoms of emerging social problems or mental illness and fail to seek help at an early stage.
- *Stigma* — Many individuals, particularly in small communities, are reluctant to seek help because of the stigma associated with mental illness.
- *Lack of Trust* — Frequent turnover in staff and inconsistency in services lead to difficulties in establishing and maintaining the credibility and trust needed between residents and workers. In addition, many native communities lack culturally relevant services, further affecting trust and acceptance.
- *Travel/Cost* — Residents in smaller communities frequently are required to travel to obtain service. The time, cost, and stress of travel in the north often inhibits clients from initiating or completing needed treatment. Cost of service (private) is also an obstacle for some.

Service Impediments: Agency

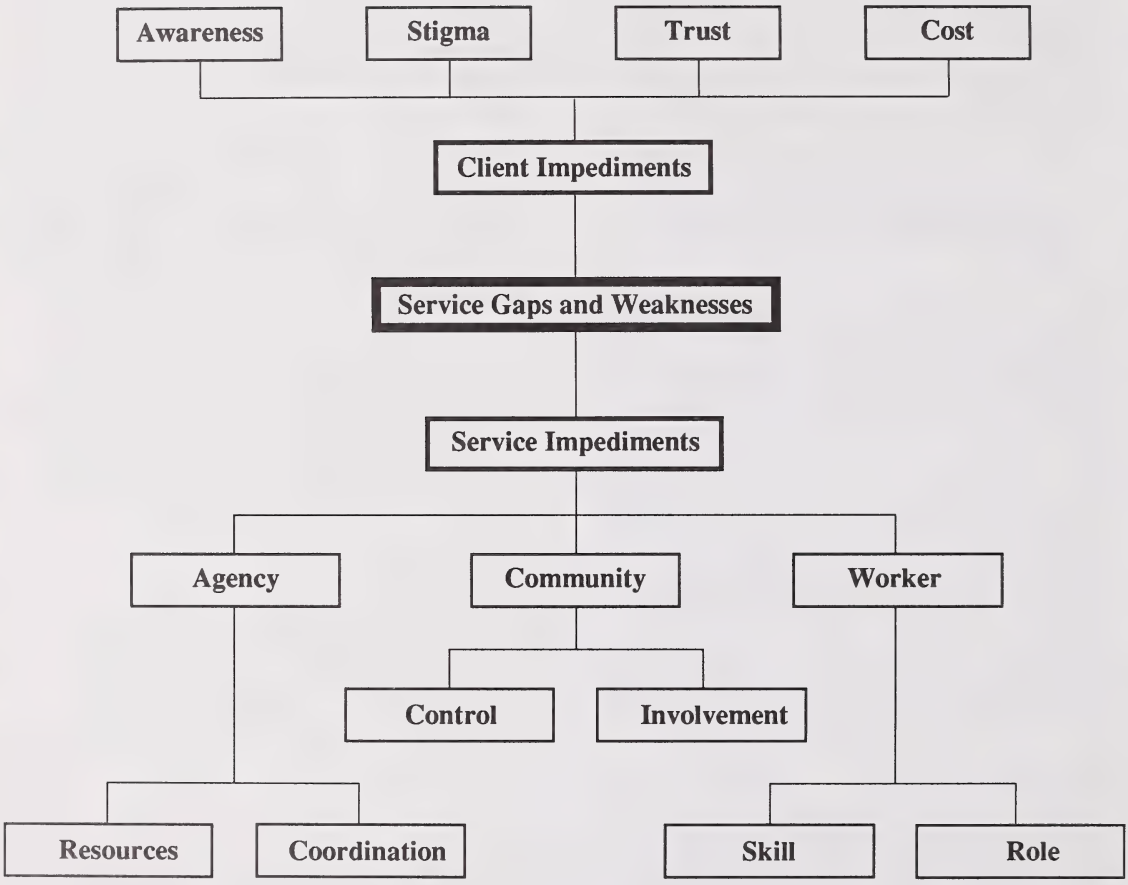
The most frequently encountered concerns dealt with obstacles that prevent or inhibit agencies from delivering the quantity, type, or quality of services required. The two major impediments were lack of *resources* and lack of *coordination and cooperation.*

Resources

Lack of facilities (to hold meetings, run groups, etc.) was considered a problem for some agencies, although the most common resource deficiency was the lack of staff to provide the services needed. A variety of causes for staff shortages were cited. These were:

- *Lack of Funding* — Many agencies do not feel they receive adequate funding to meet the demand for mandated services. Reasons for inadequate funding include:
  - low priority of mental health versus physical health and other competing services

Figure 6
Impediments Causing Service Gaps and Weaknesses



- lack of client advocacy groups to lobby on behalf of the needs of special groups, particularly in smaller centres
- formulae for allocation of funding to northern areas that do not adequately compensate for higher agency overheads, including cost-of-living, travel downtime, and staff recruitment and training costs
- lack of long-term, consistent, and reliable funding, resulting in frequent preparation of funding proposals and ongoing uncertainty in program status
- difficulties in collecting statistics required by funders, or irrelevance of such statistics in portraying local needs.

- *System Inefficiencies* — Funding does not stretch as far in the north because of the higher overheads. In addition, the current system was not perceived by some stakeholders to be as efficient as it could be, due to factors such as:
  - duplication of administration (e.g., space, reception, accounting, etc.) among agencies with separate offices in the same community — many with relatively small staff complements
  - over-reliance on services from external professional staff, leading to high salary and travel costs
  - under-reliance on services from local non-professional service providers
  - redundancies in provincial and regional administrative structures (i.e., excessive bureaucracy).
- *Insufficient Supply of Qualified/Interested Candidates* — Where funding is in place, agencies frequently have difficulties filling vacancies. Reasons include:
  - generally poor image of mental health as a career/profession
  - lack of clinical psychology programs in Alberta universities, leading to shortages in qualified candidates
  - lack of rural/remote practicums, and lack of rural/remote practice content in professional training programs, leading to lack of exposure of potential candidates to northern opportunities
  - lack of local training opportunities for "nearly qualified" individuals to upgrade and become eligible to compete for vacant positions
  - poor image of life in the north, and poor image of northern practise (i.e., unattractive jobs)
  - inadequate wages and incentives for potential candidates to consider northern practise as an option
  - insufficient agency recruitment efforts (as perceived by some communities).
- *High Staff Turnover* — Deficiencies in staff are also caused when incumbents leave prematurely. Reasons for leaving mental health positions include:
  - high job stress caused by:
    - excessive travel and high workloads
    - lack of skills to deal with frequent crises
    - culture shock and isolation
    - lack of collegial support
    - lack of supportive supervision
    - lack of peer networking opportunities
    - agency policy/mandate restrictions that prevent workers from serving in the role desired by the community
  - lack of local training opportunities, requiring staff to leave the community to pursue professional upgrading
  - inadequate wages and incentives for long service
  - lack of commitment to the north because of long-term career aspirations in the city.

Coordination and Cooperation

Another impediment agencies face in delivering services is difficulties in coordination of services between the various local and external agencies serving the community. The reasons for this were:

- *Lack of Time* — Time for interagency involvement is not formally provided for in funding for positions, and service demand does not always permit staff to participate in designing and implementing innovative coordination initiatives. Furthermore, key players/stakeholders are not always represented at interagency meetings.

- *Confidentiality Concerns* — Agencies are sometimes reluctant to pursue service integration initiatives because of concerns over preserving client confidentiality, particularly in the smaller communities.
- *Lack of Teamwork* — There is sometimes a gap in trust and communication between service providers, particularly between external/professional and local/non-professional workers, that inhibits teamwork and continuity of client service. Workers are also sometimes simply unaware of available services in referring clients.
- *Mandate Restrictions* — Known gaps in service sometimes persist because no agency serving the community is formally mandated to provide the service, and agencies feel restrained, largely due to a scarcity of resources, from initiating a service outside their mandated responsibilities.

Service Impediments: Community

A number of concerns were also voiced regarding the capacity of the community to develop and direct the services needed by its residents. The two major impediments were lack of *community control*, and lack of *community involvement and organization*.

Community Control

A reason frequently cited for gaps or weaknesses in service was the lack of community input and control in defining needs and priorities; establishing standards and methods by which services are delivered; and determining the allocation of resources. The principle reasons cited for lack of community control were:

- *Centralized Administrative Framework* — Most aspects of the current system are highly centralized in terms of planning, policy and program development, and resource allocation, with limited mechanisms for direct community input or control.
- *Lack of Respect for Local Capabilities* — Many in the north think that provincial policy-makers and funders believe that northern communities are not yet ready to assume greater responsibility, authority, and accountability for mental health service administration and delivery.

Community Involvement and Organization

Communities vary in their present capacity to initiate and implement grass-roots solutions to fill identified gaps in service. Reasons cited include:

- *Lack of Skills* — Residents sometimes lack the organizational skills and knowledge to initiate community-based programs.
- *Lack of Professional Support* — Programs that are formed often run into trouble and sometimes collapse because of the lack of professional support or backup. Professional staff are unavailable, either because of their direct service workload, or because agency policy precludes them from assisting community groups.
- *Lack of Leadership* — Community organization generally is a function of leadership from key individuals. Some communities lack the key resource people needed to catalyze grass-roots actions.
- *Lack of Community/Volunteer Spirit* — the image of volunteerism is too often interpreted as simply a "staffing" issue instead of an individual commitment to community betterment. Some communities are in the process of losing the informal helping spirit and energy, through growth and the influx of new and frequently transient residents, and are consequently more dependent upon formal services.

Service Impediments: Worker

The individuals who deliver mental health services face obstacles in providing the services clients require. Two key impediment areas are worker *skills*, and worker *role flexibility*.

Skills

It was suggested that clients do not always receive adequate or appropriate service because of deficiencies in the skills of mental health workers. The reasons cited include:

- *Lack of Training* — Not all workers who come in contact with clients are trained in recognizing and "treating" specific mental health problems, and sometimes make inappropriate referrals or prescribe/attempt inappropriate treatment (e.g., medications, counselling).
- *Crises Backing Up* — Agencies in some com-

munities indicate that crises are increasingly backing up into their caseloads. This not only inhibits the delivery of regular agency services (e.g., promotion, prevention), but puts some workers into contact with cases they feel underqualified to handle because no other referral option is available.

Role Flexibility

Workers do not always have the role flexibility to deliver the services required in a community. Reasons include:

- *Agency Restrictions* — Agency policy or mandate restrictions explicitly or implicitly inhibit some workers from performing the role requested of them in the community. Workers are typically accountable to agency-defined needs and priorities, that may not coincide with the community's.
- *Worker Self-Image* — Traditional professional roles cultivated in large metropolitan areas and reinforced within the centralized administrative system inhibit workers from considering alternative roles or from strongly aligning themselves with client and community needs rather than with their respective agency or profession.

Classification of the Range of Proposed Solutions

A wide variety of suggestions for reducing these impediments have been encountered during the course of this study. These are listed in Appendix I. These suggested solutions typically fall into the following major areas:

- *Funding* — Solutions intended to increase the priority given to mental health in general, and to increase the relative share of funding allocated to the north to better reflect community needs and the conditions under which agencies deliver services.
- *Recruitment* — Solutions intended to increase the number of potential candidates that are available, qualified, and interested in northern practise. Strategies include targeting external professionals as well as structuring jobs and cultivating local "nearly qualified" resources to fill available positions.
- *Retention* — Solutions intended largely to make the job of providing mental health services less stressful by preparing workers for the realities of northern practise and by improving working conditions.
- *Coordination* — Solutions intended to enhance communication, cooperation, and collaboration among agencies providing services in a region or community.
- *Roles and Relationships* — Solutions intended to restructure the roles currently played by various participants within the system, including central/provincial authorities; communities; local agencies; workers (professional and non-professional); and other groups, organizations, and institutions serving the community.
- *Clients/Services* — Solutions intended to remove barriers by making services more relevant and accessible to clients.
- *Service Quality* — Solutions intended to enhance the quality of services provided.

The impediments to mental health service delivery in northern Alberta, along with the suggestions for resolving them, are addressed in the next section of this report. Included are the key values and principles that northern service planners and providers believe should guide future mental health service delivery in the north, and our recommendations for implementation.

Part III
Addressing the Issues

Northern Directions

In the previous section of this report we have identified the issues and concerns that northern Albertans have with the management and delivery of mental health services, as these have been broadly defined in this study. To further enlist the support of northerners in shaping strategies for improving mental health service delivery, especially in the towns and smaller communities where deficiencies are most severe, two workshops were conducted with service providers and planners from across northern Alberta: one in the northeast (St. Paul) and one in the northwest (Peace River). The objectives of the workshops were:

- To review, confirm, and prioritize the principal findings of the study regarding impediments to mental health service delivery in the north
- To identify key values and principles for guiding future mental health service delivery and the development of service delivery strategies that are consistent with the needs, aspirations, and environments of the north
- To assess the appropriateness and feasibility of the various strategies and solutions that have been proposed during the course of this study.

Although there were some differences in the way the two workshops were conducted, their outcomes were remarkably similar. These results are summarized below.

Interrelationships and Priority of Issues

Agency, community, worker, and client impediments to the delivery of mental health services were presented to workshop participants, each of whom then identified in small group process the three most important in their community. There was strong consensus that the study had successfully identified the relevant issues and concerns. Moreover, each impediment was identified as among the most important by at least some participants, reflecting the reality that not all workers in all communities experience or perceive the same difficulties in delivering services.

Participants perceived the various impediments to be highly interrelated. For example, *lack of coordination between service providers*, an Agency Impediment, was seen to go along with Community Impediments relating to *lack of community involvement* and *control over services. Lack of resources* (insufficient funding and recruitment and retention difficulties, another Agency Impediment) was seen to underlie Worker Impediments relating to *insufficient skills* that in turn is being exacerbated by a *lack of training opportunities for local care-givers* and *insufficient time* for consultation and coordination among service providers and for community organizational activities.

Participants drew other convincing accounts of how impediments in one area interacted with those in others. Client Impediments such as *excessive travel costs, lack of awareness of existing services and of the need to obtain help*, the *stigma* attached to seeking and receiving mental health services, and *lack of trust* were closely tied to *lack of resources* and *lack of service coordination* (Agency Impediments), and to *lack of community involvement, organization, and control* (Community Impediments).

In spite of the fact that workshop participants emphasized the interrelatedness of impediments to delivering mental health services, and different participants identified different impediments as most important in their community, five issues clearly received the most attention:

1. *Lack of Resources* — staff shortages caused by insufficient funding, recruitment and retention difficulties, and system inefficiencies
2. *Lack of Coordination* — difficulties in the coordination of services among local agencies and between local and external service providers caused by mandate restrictions and lack of time to plan and implement coordination initiatives
3. *Insufficient Worker Skills* — a condition caused in large part by crises backing up into the caseloads of local service providers (particularly those working with community-based agencies) who have not been trained to deal effectively with them, insufficient preparation for northern practice experienced by some professionals, and the lack of funds to hire

experienced staff qualified to deal with the caseloads being encountered

4. *Lack of Community Control* — insufficient community control over problem definition, program planning, and resource allocation decisions caused by the lack of effective mechanisms for meaningful community input, and a perceived lack of respect on the part of central authorities for the ability and capacity of communities to assume greater responsibility and accountability for service provision
5. *Lack of Community Involvement and Organization* — overreliance on external services and service providers due to limitations in community resources needed to develop and expand community-based services.

The workshops helped to crystallize the issues themselves, and to clarify the relationships between issues that are fundamental to understanding how and why the current system is having difficulty meeting the mental health needs of many northern residents, especially those living in smaller communities.

The image that emerged from workshop discussions was one of a system under great pressure, increasingly caught in a response-to-crisis mode. Because of chronic vacancies and under-capacity in professional referral channels, local service providers are becoming overwhelmed by cases they are increasingly ill-equipped to handle, leaving them little time for promotion, prevention, and early intervention services — services that many of them have been mandated to provide. Professionals, likewise, are increasingly preoccupied with crises cases, leaving little time for developmental and support work with local service providers and other community groups. Current local and provincial funding does not permit hiring of additional staff to increase service capacity, nor to recruit individuals with the experience and skill needed to handle the increasingly difficult cases being encountered. Limited funds are available to upgrade the skills of existing staff, and caseload pressures and travel costs often inhibit workers from participating in appropriate continuing education and skill enhancement activities.

While many participants suggested that more could be done with existing resources, time pressures and travel difficulties often preclude the planning and implementation of cooperative and innovative ventures among agencies. Workers, especially those in the towns and small communities, are hard pressed to meet the needs of their clients, and often have neither the time nor the authority to initiate plans for service coordination, particularly in view of the complexities inherent in the administrative structures and mandates of the provincial, regional, and local services involved.

One other important image emerged out of the workshops that relates broadly to issues of community involvement and control. Many northern communities appear to be moving toward greater self-sufficiency and less dependence on outside services. (This sentiment was frequently encountered during our community visits as well.) Local service capacity exists in most communities, but it is often under-used. Communities desire mechanisms to cultivate and better use these resources in ways that reflect local culture, values, needs, and priorities. There is the growing sense that many northern communities have evolved to the point where they are ready to assume greater control over the management and delivery of their own mental health services — recognizing, of course, that some communities are more ready than others, and that such shifts in control are best executed within a framework that emphasizes a grass-roots community approach.

Northern Directions for Mental Health Services — Guiding Values and Principles

Workshop participants were next challenged to consider scenarios portraying strategies for managing and delivering mental health services in the north. The scenarios were used to determine whether northerners prefer strategies that essentially shore up weaknesses in the current systems, or strategies that involve a reorientation in roles and relationships. Can the issues that have been identified be satisfactorily addressed by making adjustments to current service delivery systems? Or is a different approach needed? The scenarios dealt with the following key issues:

- *Responsibility for Service Delivery and the Role of the External Professional* — Should primary responsibility for service delivery be shifted to local service providers within the community

and away from professional service providers external to the community? And, should external professional service providers principally act as educators and consultants to local service providers and the community, or principally as therapists to residents of the community?

- *Locus of Control* — Should greater control be devolved to the community from central authorities in areas relating to:

  - the definition of problems?
  - the development of strategies?
  - the design of programs and services?
  - the establishment of standards?
  - the allocation of resources?
  - the monitoring of service provision?
  - advocating and advising government about mental health concerns?

In some senses, these alternative assumptions are linked philosophically, although they might be implemented to differing degrees and in differing combinations depending on government and community will and the specific community situation being considered.

The scenarios used in the workshops provided participants with an integrated set of assumptions to discuss. Perceived advantages, disadvantages, and implications of these assumptions were elicited during small group activities.

Responsibility for Service Delivery and the Role of the External Professional

The scenarios used to address this issue essentially portrayed an alternative working relationship between professional therapists (e.g., psychologists, psychiatrists, psychiatric nurses, addiction workers, child welfare workers, etc.) and local, non-professional service providers (i.e., those providing counselling services who do not hold recognized professional certification). In the scenarios, local service providers would become the initial and primary providers of counselling services. External professionals/specialists (including those that may be based in the community but employed by an external agency) would still see unusually difficult clients referred to them by local counsellors, although their time would largely be spent consulting, case conferencing, and providing instruction on a variety of topics to local service providers as well as other community groups interested in serving in a helping role.

Despite some of the potential pitfalls noted by workshop participants (see Table 21), all groups were in favor of a shift to more service delivery by local service providers, and a shift in the role of the external professional to one primarily of educator and consultant. These strategic shifts in responsibility and roles were seen to be consistent with the desires of northern communities (especially those outside the major cities and service centres) for greater self-sufficiency and control as well as being a practical way of mitigating the chronic shortage of professionals in the north. They were also seen as good vehicles for developing community resources and providing a strong local service capacity. However, for this to work the communities must receive adequate funding and decision-making authority to develop their resources and services according to locally defined needs and priorities (i.e., local service providers should be hired by appropriately funded community-based agencies, rather than being part of provincial bureaucracies). A brief description of the important characteristics of "community-based services" is outlined in Appendix J.

Locus of Control

The scenarios used to address this issue presented a number of alternative mechanisms for increasing community input to and control over the delivery of mental health services. These included:

1. Hiring additional professionals/specialists who could travel more frequently and spend more time providing services in northern communities.
2. Strengthening local interagency committees to ensure representation by all key agencies (local and external) providing services in the community. These committees would serve a stronger role in coordinating the schedules and activities of visiting specialists with those of local service providers.
3. Creating an umbrella community-based board to facilitate service coordination and integration. The board would not have a direct service delivery role; rather, its function would be to monitor the services provided by local and external agencies, to advise these agencies, and

generally to advocate on behalf of the community regarding mental health and other services and issues affecting the mental health of the community.

4. Amalgamating all mental health related services provided to the community under a single "Human Services Agency", controlled by a local board with decision-making authority regarding problem definition, program planning, and resource allocation.

These alternatives essentially represent points along a continuum, ranging from the status quo (#1 — more resources but no fundamental change in professional role or control structures), to full community control (#4 — resources channeled to and through a community-governed agency). Group discussions resulted in additional hybrid strategies providing greater community control over funding allocation along with some agency "rationalization", though not necessarily calling for full amalgamation of agencies under a single community-based agency.

In general, the groups did not favor simply hiring additional professionals/specialists (#1) as a reasonable direction for mental health service delivery in the north. While additional professional resources were considered necessary and important in supporting any strategy to improve mental health services in the north, using professionals in the traditional way was seen as merely perpetuating the currently unsatisfactory dependence of many of the towns and smaller communities on external service providers. The strategy would do little to enhance community involvement or improve community control, since professionals would still be accountable to external agencies.

Strengthening the membership and role of local interagency committees (#2) was seen by most groups as useful. Many such committees exist in northern communities, and they could potentially play a greater role in identifying gaps, improving communication, resolving problems, fostering teamwork, and identifying opportunities for collaboration among agencies, given that they had the formal mandate and authority to do so. Many participants were concerned, however, that local interagency committees are typically limited to addressing issues at the worker level rather than at the community level, and certainly not at the government agency level. Workers are generally over-committed, and may not always have the time or the global view necessary to plan on behalf of consumers in the community. Furthermore, service providers employed by the government do not generally have the authority to make policy commitments on behalf of their agencies, and agency mandates may preclude action on many problems or opportunities identified. Consequently, local interagency committees were not seen as having the perspective or power to enhance community-level control, being more appropriate for sharing information and for dealing with specific operational issues. It was also recognized that local interagency committee meetings use person-time that might otherwise be used to provide services to clients.

The two strategies that received the most support were #3 (the creation of an umbrella, community-based board) and #4 (the creation of a community-governed human services agency). Implications of these strategies are presented in Table 22.

Possible forms, structures, and mandates of community-based boards were discussed at length. Many respondents favored a community-based board with a powerful independent monitoring, advocacy, and advisory mandate, but with no direct control over the allocation of funds. While not explicitly guaranteeing "control", such a board would be in a position, with appropriate formal authority, to exert considerable influence with agencies on behalf of community residents, and to actively promote opportunities for agency consolidation, collaboration, and coordination.

The prospect of a single community-governed human services agency was thought to simplify many of the problems associated with lack of community control and fragmentation in agency mandates and jurisdictions. However, the practicality or even desirability of consolidating all existing services (both local and external, statutory and discretionary) under a single agency operating at the community level was questioned. A broader concept of "regionalization", that might better reflect the economic realities and service needs of communities within a given catchment area, was suggested. It was also suggested that agencies need not merge in order to collaborate locally or regionally.

Table 21

Advantages, Disadvantages and Implementation Considerations of Local Service Providers Assuming Initial and Primary Service Delivery Role, with External/Professionals Serving Mainly as Consultants and Educators

Advantages
- greater flexibility of workers in meeting local needs
- greater cultural/contextual relevance of the services provided
- better client comfort, trust, and acceptance of services and service providers
- greater community control over the quantity, quality, and type of service provided
- more professional support and backup for local service providers
- better development and use of indigenous community resources
- greater accountability of professionals to the communities they serve
- better partnership/teamwork/integration between local and external service providers
- professionals learn and benefit from local context and approaches

Disadvantages
- discomfort of professionals regarding loss of control and accountability for inappropriate treatment by local providers
- potential resistance by professionals to role change
- high turnover of local providers with difficulties in training and continuity
- conflict of local providers over dual role (neighbor/counsellor)
- potential for local politics/personalities and relationships to interfere with trust/acceptance of local workers
- difficulties persist in coordination of services among agencies
- inability of community to determine own needs
- inability of community to control activity of external professionals
- strategy fails to address underlying causes of social/mental health problems in northern communities

Implementation Considerations
- may require different people to handle different functions (i.e., therapy vs. consulting/education), or specific restrictions on therapy time to ensure developmental role is not undermined
- requires changes to job descriptions of professionals defining their new responsibilities and activities
- requires changes to provincial policies to encourage and support new professional role
- requires changes in training of professionals to incorporate community development/teaching skills and to promote different self-image regarding role and relationships with paraprofessionals
- requires fuller orientation/indoctrination of professionals to the community/context
- role of community care-givers needs expanded mental health definition to formally recognize their responsibilities as primary service providers
- requires funds to pay local/indigenous helpers
- requires funds to provide local training opportunities (formal/credit)

Table 22

Advantages, Disadvantages and Implementation Considerations for an Umbrella Board and Human Services Agency (See Text)

Umbrella Board

Advantages
- greater potential for service efficiencies
- stronger advocacy for special need groups
- better reflection of community needs
- faster adaptation
- independence from agencies and service providers
- improved coordination among agencies
- improved service monitoring
- community acceptance of responsibility for local issues

Disadvantages
- lack of control over agencies
- threatening to agencies
- lack of influence over provincial policies
- potential for personal biases and personality conflicts
- lack of board resources and continuity

Implementation Considerations
- need legal constitution and formally recognized mandate
- need agency endorsement and cooperation
- need financial resources to carry out board work
- need formal relationship with provincial/regional policy makers and mechanisms for regular input
- need credible board with good knowledge of both community and services, yet independent of agencies

Human Services Agency

Advantages
- efficiencies in consolidation
- flexibility in allocation of funds
- better reflection of community needs
- faster adaptation
- mandate covers all community residents (no mandate gaps)
- single entry for clients
- more locally based services
- fewer client problems with stigma/awareness
- easier to promote "health" message
- community empowerment
- community accountability

Disadvantages
- community-level accountability
- potential for personal biases and personality conflicts
- resistance from the existing agencies being phased out
- potential loss of professional jobs using more local "generalists" in place of visiting "specialists"
- potential for downgrading of services through loss of specialties
- potential burnout of generalists
- narrow/inbred perspective

Implementation Considerations
- need provincial agreement to channel current agency funding through central authorities to the community
- need significant delegation of current provincial service responsibility and funding to community authorities
- need credible boards with good knowledge of both community and services

Conclusions

Health & Welfare Canada, in its 1988 report *Mental Health for Canadians: Striking A Balance*, offered a definition of mental health from which the guiding mission for mental health services may be derived. This is paraphrased below:

> To enable the individual, the group, and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice, and the attainment and preservation of conditions of fundamental equality.

It is clear from the input received from the wide variety of stakeholders who participated in this project that northerners have a broad view of mental health consistent with the above mission statement, focusing not on "illness" and traditional institutional care, but rather on promoting healthy individuals in interaction with healthy community environments. The workshops helped to crystallize the aspirations of northerners for a mental health service delivery system that is an integral component of the community infrastructure, and that develops as the community grows in balance and in concert with related social and economic developments.

Two overriding development principles emerged from the workshops.[7] These were:

- ***Prominence of Local Service Providers* — to the greatest extent possible, services should be provided in the community by residents of the community. Local service providers must be identified, developed, activated, and supported as the initial and primary givers of care to community residents, with external professional/specialists serving in a developmental and support role as educators and consultants.**
- ***Local Input and Control* — to the greatest extent possible, decisions regarding needs, priorities, services, and resource allocation should be made at the community level. Mechanisms must be implemented that provide for grass-roots input, and for delegation of responsibility, authority, and accountability to the community level.**

Any changes made to the current approach should be guided by these two principles to ensure that the system develops in a manner consistent with northern values. Adherence to these principles will have the following impact on the issues that were identified during the course of this study:

Community Impediments

- *Lack of Control* — Delegation of greater decision-making authority to the community regarding service delivery will fundamentally alter governance and power, and result in greater community control.
- *Lack of Involvement* — Using external resources to develop and support local resources is a major human resource and service development initiative. Delegation of authority further enhances community involvement by shifting responsibility and accountability to the community level, fostering the emergence of community activism and leadership.

Agency Impediments

- *Lack of Resources* — Changing the role of professionals practising in the north will enhance the attractiveness of northern practice and mitigate recruitment and retention problems. Using more local resources also greatly diminishes recruitment and retention issues, and will generate resource efficiencies by reducing the proportion of professional travel and salary costs in direct service delivery (e.g., therapy). Greater community control will foster improvements in coordination and collaboration, further enhancing resource efficiencies. Community-based boards will also provide a stronger and more coherent funding lobby on behalf of special needs groups.
- *Lack of Coordination* — Changes to the relationship between professionals and paraprofessionals will foster improved teamwork. Closer coordination and cooperation at the agency level will be fostered with stronger

[7] It should be noted that these principles are consistent in many respects with those identified in recent provincial reports. See *Caring & Responsibility: A Statement Of Social Policy For Alberta* (Government of Alberta, 1987); *Mental Health Services In Alberta: Sharing A Vision Of Better Health* (Alberta Health, 1988); and the evaluation report of the *Alberta Suicide Prevention Program.*

monitoring and advocacy responsibility and authority at the community level.

Worker Impediments

- *Lack of Skills* — Community resources will be better prepared to handle the caseloads they face with access to education and consultation from professionals working as part of the service delivery team.
- *Role Restrictions* — the community will have greater influence over agency policies that govern the roles played by service providers, freeing workers from conflicts in performing the function needed in the community. Establishing a new working relationship between external professionals and local service providers will also help to break down traditional stereotyping that restricts service providers from considering alternative roles.

Client Impediments

- *Excessive Travel/Cost* — Use of local resources as primary service providers will greatly reduce the need for residents to travel to receive service.
- *Lack of Awareness* — Greater community control and the engagement of more local residents as service providers (formal and informal) will enhance community awareness of available services.
- *Stigma* — Enhancement of the indigenous service capacity within the community will generally increase the exposure of residents to mental health issues framed and discussed in a relevant local context.
- *Lack of Trust* — Residents are perceived generally to have greater comfort with services designed locally and provided by local resources.

The potential benefits of implementing strategies consistent with the two key development principles are significant. While support for these principles is strong among stakeholders within the system, specific concrete proposals were met by objections from some. For example, when discussing changing roles for external professionals in relation to local service providers, questions were raised about professional responsibility and liability when clients had bad outcomes. Questions were also raised about the kind and degree of control external professionals might have over the kinds of services a local service provider was authorized to deliver. Some participants seem particularly reluctant to see any reorganization of agency boundaries as might be envisioned by the development of locally controlled human services agencies. Some of this reluctance was attributable to participants' satisfaction with their current employment situations. However, the reluctance of others may have been due to the fact that service providers who are currently treated as professionals in one agency would not be viewed as professionally qualified by another. Thus, any reorganization of agency boundaries is bound to raise legitimately unsettling questions of status and qualification.

Even with these expressed reservations, there was strong support for developing mechanisms that would enable a greater degree of partnership to be established between communities and central provincial authorities in defining, designing, and delivering mental health services in northern Alberta. It was recognized and agreed that good processes for community involvement and input would almost inevitably lead to different solutions being adopted in different northern communities. Because there was general recognition that there is not one but several norths, the potential diversity of solutions offered by a process that emphasizes community involvement and input was seen as a strength, not a weakness. At the same time, it was recognized that this would constitute a fundamental shift in power away from the central authorities and into the hands of residents of northern communities.

Recommendations

Many of the specific solutions proposed by northerners to address weaknesses in the current approach to mental health service delivery are consistent with and support the two key principles articulated in the previous section of this report: Prominence of Local Service Providers, and Local Input and Control. The following are recommendations and actions for implementing these principles, along with recommendations for addressing other important issues concerning mental health services in northern Alberta:

1.0 We recommend that the province establish appropriate mechanisms and the necessary resources to enable communities to employ local personnel to provide a wide range of community-based mental health services.

Actions for Implementation:

1.1 Develop and deliver appropriate formal training programs for local service providers.

1.2 Change the role of both visiting and resident professionals to serve as educators and consultants to local service providers, including paraprofessionals, traditional healers, informal care-givers, and social support and self-help groups.

1.3 Ensure each non-professional service provider in a community has formal links to professional service providers (local or external, as appropriate) for referral, follow-up, and case consultation, and that their interdependent relationship is clearly defined.

1.4 Adjust professional training programs to ensure that graduates are prepared to assist northern communities to develop local resources and control, and to function as educators and consultants.

2.0 We recommend that the province promote the establishment of regional mental health boards that will enhance northern communities' input to and control over decisions regarding needs, priorities, services, standards and the allocation of mental health resources in northern Alberta.

Actions for Implementation:

2.1 Provide regional mental health boards with the mandate and resources they need to ensure that the delivery of services to northern Albertans is consistent with the promotion of mental health as defined in this report. It should be explicitly recognized that these boards may differ from one region to the next, and that some may serve a single community while others serve a cluster of communities. Regional boundaries are to be defined by the communities being served in consultation with central authorities.

2.2 At a minimum, ensure that the regional mental health boards in northern communities have the authority and resources to monitor local agency services, advocate on behalf of residents to agencies regarding desirable changes in agency mandates and services, and advocate on behalf of both local residents and agencies to senior levels of government.

2.3 Implement formal mechanisms that will enable regional mental health boards in northern communities to become actively involved in provincial planning processes, including those of the departments of Alberta Health, Alberta Family and Social Services, Alberta Alcohol & Drug Abuse Commission, and the Solicitor General.

2.4 Establish a staff position to facilitate community resource development within each region.

3.0 We recommend that Alberta Health (Mental Health Division) and the Public Service Commission take immediate steps to fill professional mental health positions in northern Alberta, and to develop a long-term recruitment and retention strategy for filling vacancies quickly and reducing staff turnover.

The following are *recruitment strategies* that should be considered:

3.1 Decentralize the full range of personnel functions to the northern regional levels so

that recruitment can be handled more efficiently and effectively.

3.2 Allocate payroll dollars from vacant positions to recruitment costs and incentives.

3.3 Increase monetary incentives to fill vacancies.

3.4 Promote cost-sharing of positions between agencies (local and provincial) to provide more attractive compensation packages and more attractive jobs.

3.5 Establish clinical psychology training programs within Alberta universities to increase the supply of trained professionals for positions in the north.

3.6 Establish a provincial mental health institute to enhance the image of mental health and encourage more people to consider a career in mental health.

3.7 Encourage northern mental health research and the publication of articles exploring northern issues and describing successful programs in the region.

3.8 Encourage the inclusion of rural/northern content in professional training curricula, and provide financial and local agency support for northern field placements.

3.9 Provide local training of northern resource persons via extension.

3.10 Provide bursaries with return-service commitments for training northern resource persons.

3.11 Advertise and promote the north to students and professionals.

The following are *retention strategies* that should be considered:

3.12 Inform candidates of job/community environment before hiring.

3.13 Develop specific orientation packages to job and community for new workers.

3.14 Establish community orientation before assigning specific caseload in new job.

3.15 Give greater consideration to travel demands as part of overall workload allocation.

3.16 Provide additional funding for conference and workshop travel.

3.17 Encourage and support membership and participation in professional associations.

3.18 Provide inservice training through distance education technology.

3.19 Promote peer networking opportunities.

3.20 Avoid single person offices by encouraging co-location and service integration with other service providers.

3.21 Increase job sharing.

3.22 Increase autonomy and flexibility in worker roles to enable greater responsiveness to local conditions.

3.23 Accelerate salary grids for northern workers.

3.24 Provide local training opportunities to reduce the need to leave the community for professional upgrading.

4.0 We recommend that the province reallocate funding to provide better support for community-based mental health services in the north.

Actions for Implementation:

4.1 Reallocate funds from institutional services to community-based services.

4.2 Allocate a greater portion of provincial mental health funding directly to community-based agencies.

4.3 Adjust provincial funding formulae to compensate northern mental health agencies for training and travel overhead.

4.4 Increase support to joint agency programs, the pooling of resources, and single entry and coordinated case management initiatives.

4.5 Encourage the development of community health centres.

4.6 Increase privatization of service delivery (with community input and appropriate standards and evaluation).

5.0 We recommend that the province, in consultation with consumers and providers of mental health services, define basic mental health services that all northern Albertans have

the right to access, regardless of where they reside in the north.

6.0 We recommend that the province selectively insure private psychological and social work services under the Alberta Health Care Insurance Plan for residents of rural northern Alberta communities on a trial basis with an appropriate evaluation.

7.0 We recommend that the province initiate a comprehensive campaign to increase awareness of mental health services, and to reduce attitudinal barriers among northern residents.

8.0 We recommend that the province allocate more resources to mental wellness and to mental health promotion and education initiatives.

Appendices

Appendix A
Strategies from the Literature

Strategies from the Literature

Searching the literature for accounts of effective mental health service delivery strategies in northern Canada can be a frustrating experience. As is the case with most northern issues, one finds considerable material documenting problems with very little attention paid to proposed solutions and only rare evaluations of the effectiveness of innovative strategies. The following discussion then must be indicative rather than prescriptive. It simply is not possible to advance a particular strategy as "proven effective" in certain types of northern communities. However, one can look at various approaches that have been tried, along with their underlying rationale, for ideas and suggestions of an appropriate strategy for one's own community. This material is not offered as an exhaustive annotated bibliography of all northern service delivery strategies. Rather, selected approaches are presented as illustrative of common themes apparent in the literature.

Context as a Focus for Strategy

> Through a contextual-focused approach, there is no need to search for the one best way for northern rural practice. Instead, methods arise out of a specific context (Nelson, 1986, p. 7).

An excellent starting point for approaching this literature is Nelson's comprehensive case study of Peninsula, a mill-town on the north shore of Lake Superior. The service delivery issues in Peninsula reflect those in many northern Canadian communities, and the proposed strategy introduces the major themes around which the other strategies have been grouped for this review.

Mental health services in Peninsula were offered through a number of distinct agencies with differing mandates and delivery patterns. Some workers were based in Peninsula and served only the town; some workers based in Peninsula served other communities along the north shore as well as Peninsula; some were based in other north shore communities with a catchment area that included Peninsula; a fourth category of specialist workers were based in Thunder Bay (3 1/2 hours away) and travelled to Peninsula on regular visits or on an as-needed basis. In addition, some local residents travelled to Thunder Bay to receive services. Nelson concluded that this pattern "reinforces each worker being accountable for agency-defined client need . . . The community is forced to adapt its needs to what services are available" (p. 12).

Nelson also examined the 14 mental health boards and committees that determined policy for service delivery in Peninsula. Again she found a pattern of overlaps and gaps. Some boards were community-based with all local members; some were regional with representatives from Peninsula; some had no representatives from Peninsula at all; many met in distant locations making attendance from Peninsula difficult for much of the year. Nelson concluded that this pattern "leads to enormous confusion for Peninsula in terms of what say they have for policies made about services delivered to their community" (p. 16).

Nelson's proposed solution is based on the assumption that the primary purpose of mental health agencies is creating healthy environments, not simple delivery of service. The suggested strategy involves creation of an umbrella community-based board "to facilitate integration of all service delivered to the community." This board would have the following functions:

- monitor the relevancy of agency delivered services within the community
- community advocate for community social service concerns
- community advocate for issues impacting on the community
- community advisory group to all district and cluster community level boards with agency services that are available to local community residents (p. 18).

Agencies working through such a community-based board would have to modify some of the expectations of their workers. Nelson suggests workers will need time for community orientation, "hanging around" to become aware of local priorities and existing support networks. Workers should be evaluated on performance related to community priorities and not standards imposed from outside. Flexible horizontal linkages must be encouraged at both the local interagency level and between local workers and the specialists based in

Thunder Bay. It will also be necessary for northern mental health workers to develop a perspective of mutuality "and [they] must not see informal helping as merely a complementary strategy to professional helping, but as the primary vehicle for providing help" (p. 27).

Overall, Nelson's proposed strategy illustrates a shift away from a problem-solving focus towards a context focus. Bureaucrats and workers would not determine what is best for clients without considering "the context in which help is sought." Most mental health disciplines accept environmental influences on problem situations, but are reluctant to accept that the "form of helping must also arise out of the environmental context" (p. 5). The strategy proposed for Peninsula includes features of: cooperation between local workers and outside specialists; a focus on local informal helping networks; a core structure for management; and altered expectations for local staff. Each of these themes will now be illustrated and elaborated by presentation of selected service delivery strategies from other jurisdictions.

Strategies Using Professionals as Consultants

Following from their survey of rural mental health consumers, Flaskerud and Kviz (1982) suggested:

> A solution that seems to take into account the preference of consumers for health services and the low supply of mental health professionals is to use the professional in a consultation and education role. In this role, rural community mental health practitioners could provide indirect services for mental health needs through primary care-givers in the community (p. 116).

Timpson (1983, 1984) described just such an innovative strategy for delivery of mental health services in northwestern Ontario. The Sioux Lookout Zone covers a huge area which includes 27 remote reserves inaccessible by road. During the 1970s, clinical psychiatric services were provided by consultants from the University of Toronto Department of Psychiatry who visited each community twice a year. Follow-up services were provided by two non-native field workers based in Sioux Lookout. Perceived by all stakeholders as inefficient, this service delivery model was altered substantially in the 1980s.

Coordination of mental health programs for the entire region became the responsibility of a social worker based in Sioux Lookout. Bilingual native persons were hired as the travelling field workers to visit outlying communities. In several of these remote settlements, band councils hired local residents (natural helpers) to offer counselling and support in their own communities. The role of the visiting psychiatrists from Toronto has shifted dramatically. Now they spend most of their time as educators/consultants giving seminars to the local indigenous counsellors on topics such as grief, suicide, and marriage counselling. These seminars are conducted with interpreters and heavy use of role play in an attempt to connect with local situations and concerns.

Another clear example of the professional as consultant to local workers comes from Atikokan, Ontario, where two iron ore mines closed in the early 1980s. A pilot project known as the Transition Counsellor Service developed to address the considerable disruption for a large number of employees and their families (McKay, 1987). Direct service in the community was provided by a counsellor, "a local woman with strong natural helping skills" (p. 272) who offered a public education program about stress and services related to unemployment, assisted in the establishment of self-help groups, offered counselling with individuals and families, and assisted with job searches. A professional social worker from Thunder Bay acted as consultant and evaluator for the project, supporting the local worker. The consultant was also in a position to document the activities in Atikokan as a model for other northern communities facing similar pressures.

Strategies Using Existing Support Networks

Fuchs (1985) described a strategy developed as part of the outreach program of the health centre in Churchill, Manitoba. Focused on social support networks, this program attempted to enhance the natural and informal helping systems already present in the community, and to develop new "event-centred support groups" for persons "known to be at risk due to their common expo-

sure to certain life events and transitions requiring extensive social readjustment" (p. 210). Three specific support groups are described. The first involved mothers in the community, both long-term residents and newcomers. The second was a support group for nurses in town, designed to assist with orientation for new staff, offer support for the very stressful job, and build linkages with other community members and groups (often the job left little time for this unless such formal plans were made). The third group developed was more of a mutual aid group where referred agency clients, both old-timers and newcomers, could work on improved social skills. All three of these groups were aimed at improving and expanding existing support networks in the community by building new linkages for sharing and overcoming the common separation between long-term residents and transients.

In her discussion of strategies for improving services to AIDS victims and their families in rural areas, Rounds (1988) also emphasized "coordinating, strengthening, and expanding existing community resources and networks rather than creating new delivery systems" (p. 259). Close cooperation between formal agencies and informal community networks at the local level is essential, as is coordination between discharge workers at the urban hospital and local mental health workers who provide follow-up services in the rural community. Rounds suggests building support networks by approaching on a one-to-one basis those who might be interested, rather than a forum or town hall meeting which could serve to focus resistance.

A study of the impact of oil-related boom expansion in Sydney, Montana, proposed a comprehensive community helping system "predicated on the primacy of the informal network for service provision . . . The CCHS considers professional services as a last resort . . . The proper role of professionals is to augment the informal support system" (Bates, Clark, and Bertsche, 1980, pp. 203-204). These authors suggest a specific six-task strategy:

1. Identification (of existing and potential informal resources)
2. Assessment (strengths and weaknesses of prospective resources)
3. Activation (engagement of informal resources, motivation)
4. Creation (of new support networks to fill gaps)
5. Maintenance (support for informal resources, also referrals)
6. Monitoring & Evaluation (how might informal networks and workers improve?).

In a more recent study of residents of 13 remote boom towns across Australia, Neil and Jones (1988) found that most of the variance in psychological health scores "could be attributed to the effects of loneliness" which again suggests a focus on strategies to expand and develop social support networks.

Another possible strategy is for a local informal support group to "activate" itself as a grass-roots advocacy group. Bachrach (1986) documented the lack of services for the chronic mentally ill in Juneau, Alaska: one psychiatrist served the entire city and region; no medical backup or visiting service from outside had been developed; the only state mental hospital in Anchorage was very expensive to reach and difficult for follow-up; many chronic mentally ill ended up in jail through lack of any community-based treatment alternatives. In response, the Juneau Alliance for the Mentally Ill "has become creatively involved in advocating for services for chronic mental patients." Affiliated now with a national body, this local grass-roots effort has promoted a mental health needs assessment of the Juneau area and "has been actively negotiating with the state of Alaska for the development of jointly sponsored residential and day care services for the chronic mentally ill" (p. 670).

Strategies Involving Management

A common observation in the literature is that the linear management style of bureaucratic human service organizations often restricts the ability to respond effectively to local issues in northern communities. One proposed solution involves a structural paradox: "a responsive human service organization needs both a traditional bureaucratic core to serve the ongoing and mandated functions of the agency; and a fluid temporary structure at the interface between the agency and its catchment environment" (Nelson, 1985, p. 137). In other words, the effective northern agency has a need

for a bureaucratic structure to handle predictable and steady functions plus flexibility around the edges to allow quick adaptation and response to local problems and issues without rigid rules and regulations.

The model has been illustrated with the example of Kinark Child and Family Services, an integrated children's services agency in northwestern Ontario (McKay, 1987; Nelson, 1985). The agency core is a recognizable bureaucratic structure featuring a board, an executive director, and supervisors of staff units. This core is responsible for "tight properties" such as agency values (family-focused, community-based service), action bias (experiment, try things out, responsible feedback and program evaluation), and client orientation (feedback from clients and community, continual improvement of service). Guided by this structure, line workers can benefit from the "loose properties" of worker autonomy (staff trusted and respected, evaluated on results, collegial consultants, individualized staff training opportunities), and innovation (work with existing community networks, *ad hoc* interdisciplinary and interagency project teams).

Peters and Waterman (1982) in their book *In Search of Excellence* suggested that such simultaneous "loose-tight" properties would be beneficial for most organizations. When "the basic form is clear, flexibility around the base structure is made easy . . . Excellent companies appear to be reorganizing all the time. They are. But most of the reorganization takes place around the edges" (p. 310). This creative flexibility around the edges was also advocated by Elmore (1979):

> The capacity to implement originates at the bottom of organizations, not at the top. If one accepts this view, the important business of implementation consists not of developing more complicated techniques for managing subordinate behavior but of enhancing the capacity of the smallest unit (p. 215).

While this approach obviously is not limited to northern settings, northern agencies do appear to have some definite advantages when considering such a "tight-loose" structure: smaller size and scale of operations, less rigid agency boundaries, less coordination time, and fewer rigid bureaucratic traditions to overcome than many of their southern counterparts (Heyman and VandenBos, 1989; Wharf, 1985).

Strategies for Recruitment

With regard to recruiting for rural mental health positions, Miller (1981) suggests a strategy that involves all staff in each step of the process. A job description and qualifications, plus a profile of the ideal candidate, are formulated with input from every staff member. Each serious applicant is then sent a package of materials including the job description, qualifications, agency brochures, maps of the area, list of community resources and recreational activities in the area. During any subsequent interview, the applicant should be asked about his/her motivation for seeking a rural lifestyle, and presented with typical local practice dilemmas for comment. Miller stresses providing "specific, honest information about the nature of the job, the agency, and the practice community. Don't oversell the job or the community" (p. 149).

Often in northern communities, however, the problem is not how best to screen the applicants but rather how to generate a pool of applicants in the first place. Little has been written on this issue although many other professions are now struggling with the same problem here in Alberta. The Rural Health Care Association of Alberta organizes an annual fair where students in medicine and health-related professions are invited to visit booths set up by rural and northern communities advertising job vacancies, local resources and attractions. An *ad hoc* Committee on Physician Recruitment and Retention in Rural Alberta has developed recommendations regarding such things as fee differentials for rural practice, student bursaries with return-in-service commitments to rural practice, rural practicum experiences for students, locum pools of practitioners to fill in for local practitioners who are away from the rural community for continuing education or vacation (Zadderey, 1988). All of these appear to be appropriate responses, but there is no hard evidence of their effectiveness. Currently, the Alberta Health and Social Services Disciplines Committee is conducting a study of incentives used to recruit and retain health and social service personnel in rural Alberta, but the project is not yet completed.

Once a mental health worker has been hired for a

rural/northern setting, Miller (1981) proposes a strategy for orientation which includes the following specific activities:

1. Discussions with staff about the stresses they experienced when coming to the community
2. Meetings with colleagues to discuss what therapeutic approaches work best with the agency's clientele
3. Role plays of typical stress-provoking situations such as meeting clients outside the agency
4. Supervisory conferences regarding crucial political issues to anticipate and avoid
5. Introductions to key community agencies, leaders, and spokespersons
6. Reading of pertinent professional literature descriptive of rural life and practice (p. 150).

There is strong support in the literature for the inclusion of rural and northern content in the school curriculum along with appropriate practicum placements for students preparing for mental health practise outside of urban settings (Collier, 1984; Farley, Griffiths, Skidmore, & Thackeray, 1982; Ginsberg, 1982; Jerrell & Knight, 1985; Miller, 1981; Westwood, 1983; Zapf, 1985). The University of Alberta has recently announced that placements in rural family medicine will be compulsory for half their medical students, but so far there is nothing similar to ensure a pool of sensitized northern mental health practitioners.

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Appendix B

Annotated Bibliography of Provincial Briefs and Documents Concerning Mental Health Services in Northern Alberta

Summaries of Briefs Submitted to NADC

1. Share of Funds for Health Services. **Peace River Health Unit. Village of Hines Creek (1982).**

Issues Identified:
- Need for more prevention and health promotion.
- Too large a portion of budget to hospitals.

Solutions Proposed:
- More dollars to community.

Comments:
- Increased funding for community programs would be beneficial; however, how services are delivered is still an issue.

2. Service Needs Required Within the Smoky River Region. **AMH (1989).**

Issues Identified:
- Little or no intervention counselling.
- No professional mental health staff (psychologists, psychiatrists, or psychiatric nurses) in the area.
- No services provided by Alberta Mental Health.
- Need to travel to Grande Prairie or Peace River to receive services.
- No backup resources in the area (i.e., private practice psychologist).

Solutions Proposed:
- In-region access to a mental health worker and a clinical psychologist to provide psychiatric assessment and referral, crisis intervention and follow-up counselling.
- Consistency of service out of one office.
- Input from mental health professionals in developing new and expanding existing prevention programs.

Comments:
- Issues and solutions are similar to those voiced by other northern areas.
- Solutions are quick fix in nature and are not likely to alleviate the underlying problems: recruitment and retention of staff.

3. Town of Peace River **(1989).**

Issues Identified:
- Concern regarding funding for a women's shelter in Peace River.
- Specific concern about funds for volunteer coordination services, public education, follow-up services and outreach services. These do not fall into the category of emergency services; therefore, are not provided by the province.

Solutions Proposed:
- As a regional facility the municipalities served should all contribute to the funding of the programs.

4. CMHA Barrhead and District Branch **(1989).**

Issues Identified:
- Funds for ongoing services for Swan Hills area.

5. North Safe Home Network Society. **High Level (1989).**

Issues Identified:
- Funds to operate a satellite shelter ($46,000 of $120,000 covered by FCSS).
- Capital costs.
- Education for volunteers.
- Public and professional awareness of the problem.
- An approach to the problem of family violence which addresses prevention, crisis intervention, follow-up and evaluation is necessary.
- Availability of services to remote areas.
- Issues such as isolation, poor transportation, fewer services, lack of anonymity, cultural differences are also identified.

Solutions Proposed:
- Long-term funding commitment for the operation of the Safe Home Network Society and its satellite shelter; matching grant.
- Provision of expert assistance in education of volunteers dealing with victims of family violence.
- Expansion of emergency services into remote areas which are difficult and expensive to access.

- Increased public awareness programs for the need for medical services, counselling, legal assistance programs, self-help centres, protection services and emergency housing programs.
- Increased legal assistance programs for victims where not readily available, affordable or understood.

6. Peekiskwetan "Let's Talk Society": Proposal for Community/Crisis Counsellor. **Wabasca/ Desmarais (1985).**

Issues Identified:
- Community has an "alarmingly" high prevalence of social problems (suicide, violence, child neglect, alcohol and drug abuse).
- Availability of one mental health worker for two days/month was not adequate.

Solutions Proposed:
- Major improvement in socio-economic/environmental conditions to reduce incidence of social problems.
- Need for a full-time qualified resident mental health worker or a psychiatric social worker to provide counselling services in areas such as suicide, sexual abuse, battering, alcoholism and other family problems.

7. Independent Living Services of Grande Prairie **(Feb. 1987).**

Issues Identified:
- Need to explore the goals and expectations of handicapped individuals and their families and communities with respect to their future.

Solutions Proposed:
- To undertake a study of this issue.

8. Independent Living Service of Grande Prairie **(Apr. 1987).**

Issues Identified:
- Provides background on the Independent Living Service which provides people with the opportunity to live on their own within the Grande Prairie community. Many clients are mentally handicapped or mentally ill. Intent of the study is to increase awareness of the program and of the needs of clients.

9. Pilot Project for Delivery of Health Services to Isolated Northern Communities. **Peace River Health Unit Board (1988).**

Issues Identified:
- Issues which impact on health care delivery:
  - jurisdiction — roles of federal, provincial and municipal providers
  - legislation
  - health policy — policy which recognizes the needs of isolated northern communities.

Solutions Proposed:
- Undertake a pilot project for the delivery of health services to be:
  - community-based
  - managed by community steering committee
  - multisectorial
  - free of legislative constraints
  - two-year with evaluation.

10. A Psychiatric Group Home for Northeast Alberta. **CMHA. Fort McMurray (1983).**

Issues Identified:
- Lack of lodging and rehabilitation for psychiatric patients post-hospitalization when a controlled environment is the treatment of choice.

Solutions Proposed:
- Psychiatric group home for Fort McMurray.

Comments:
- At the time of the proposal the area seemed to have the right kind of backup resources to support the group home proposed.

11. CMHA Report on Recruitment in the Mental Health Related Professions. **Fort McMurray (1987).**

Issues Identified:
- Recruitment and retention of staff.

Solutions Proposed:
- Increased salaries.
- Returning subsidy programs.
- Peer networking.
- Better recruitment strategies.
- In-house training.

Comments:
- Each of the ideas presented is an option. How they are implemented would determine their viability.

12. FCSS Brief to NADC **(December 1988).**

Issues Identified:
- Understaffing of mental health services in Athabasca.
- Current staff are overworked — cannot provide preventive level care.
- Institutional care could be avoided if community services were available.
- Increase in child abuse and suicide.

Solutions Proposed:
- No specific strategies proposed.
- Request that Alberta Health take strong measures to provide adequate mental health services for the area.

Comments:
- The community of Athabasca is best equipped to determine the measures that need to be taken to bring the service level up to adequate standard.

13. Mental Health Services in Rural Alberta. **Peace River Health Unit (1989).**

Issues Identified:
- Basic mental health services do not exist in rural Alberta.
- Falher/McLennan are dependent on other areas that have chronic staff vacancies. The result is inconsistent service.
- Community-based services are unavailable.
- Mental health problems have to be dealt with by the local hospital or require travel 90 km to 180 km.
- Elderly in the community with psychogeriatric or chronic mental problems are not having their needs addressed.
- Children's mental health is considered a priority but no funds are available.
- Needs of natives have not been addressed.

Solutions Proposed:
- Major recruitment initiative.
- Job enhancement.
- Need for full-time psychiatrist in Peace River.
- Psychiatric unit for Peace River Hospital.
- Full-time mental health worker for Falher/McLennan.
- Needs assessment and community satisfaction survey be carried out.

Comments:
- Proposed solutions would ease the problem; however, a more holistic strategy should be determined.

14. Lac La Biche and District Community Resource Network **(1989).**

Issues Identified:
- Mental Health staff vacancies.

Solutions Proposed:
- Fill positions.

Comments:
- Quick fix.

15. Filling the Gaps: Family Violence Services in Northeastern Alberta. **Lac La Biche (1988).**

Issues Identified:
- Special needs of northern rural community have not been recognized by government (e.g., satellite shelters do not receive financial support).
- Need to coordinate family violence and women's initiatives for the region.
- Need for counselling and follow-up services for all family members; an attempt to break intergenerational cycle.
- Need for crisis lines.
- Need for public education.

Northern Issues:
- Transient nature of the population in the oil areas does not allow for the development of community.
- In areas where community exists people are reluctant to seek help because of lack of anonymity.
- Large native population is removed from information and services because of financial hardship and language and other cultural barriers.
- Public services are few and far between

- Isolation, poor transportation, lack of private telephone lines or telephone service, lack of safe shelter, higher cost of living, lack of population base to draw volunteers or funds.

Solutions Proposed:
That government:

- continue funding resource and information sharing and coordination in northeast Alberta
- recognize and fund satellite shelters in Lac La Biche, St. Paul, and Athabasca
- provide adequate trained leaders for support and therapy groups
- staff existing mental health positions
- provide treatment programs for men who batter and these be court-mandated
- establish a toll-free crisis line and fund to assist community-based volunteers
- establish a provincial advisory committee to develop standards, training and coordinated efforts for the community-based crisis line and follow-up volunteers
- develop and implement a multi-media campaign
- fund the position of information officer as outlined in the five-year plan prepared for SS North Region
- take into consideration the unique costs of living and working in rural and northern Alberta when the province is calculating funding levels.

Comments:
- Regional crisis line and involvement of volunteers is a good idea.
- Staffing recommendations are quick fix and do not get to the root of the problem.
- The northern issues outlined are important and should be communicated in a clear concise manner.

16. Supplementary to "Filling the Gaps." **Lac La Biche (1988).**

Issues Identified:
- Support issues presented in "Filling the Gaps."
- Particular concern with the need for mental health staff and crisis lines.
- Need policy guidelines for crisis lines.

Solutions Proposed:
- Review of process of recruiting, orienting and staffing mental health offices.
- Regional and community-based response teams and committees for crisis lines.

Comments:
- Regional crisis lines could be one way of allowing access to the region in a cost-efficient manner if telephone lines are available.

17. Native Communities Under Attack — Case Study: Grand Centre/Cold Lake Area **(1989).**

Issues Identified:
- Priorities for the town are housing, recreational facilities, service agencies. However, the needs of natives are forgotten.
- Testing of the cruise missiles has put a psychological stress on the locals.
- Native people have been hard hit by the oil development; natives viewed as a problem.
- Dramatic increase in youth suicide attempts on both the settlement and the reserve.

Solutions Proposed:
- Satellite centre with appropriate resources to intervene and create change on behalf of natives.

18. Athabasca Health Unit Board **(1981).**

Issues Identified:
- The Health Unit services including public health inspection, speech pathology, home care and early intervention programs are all stretched to the limit. (Although this brief is dated 1981 the same concerns exist today.)
- Difficult to provide services to remote areas.

Solutions Proposed:
- Requesting support of NADC in their request for increased government funding to enhance programs and services and increase staff complements.

19. Request for Revisions to the Canada Health Act. **Athabasca (1984).**

Issues Identified:
- Canada Health Act should by revised to allow for recognition of "north" issues.

Solutions Proposed:

- Community health centres and industry must be recognized as health care delivery sites.
- Professional recognition for nurses.
- A health policy is required that includes promotion, conservation and restoration of health; emphasizes prevention of illness and handicaps; and provides supportive care.

20. Statement of Mental Health Service Needs of Fairview and District. **Fairview Interagency Mental Health Committee (1990).**

- This brief contains a request for Alberta Mental Health to expand service from one day a week to a full-time position, to be located in the town of Fairview.
- A list of agencies that supply mental health resources to the community from Peace River, Grande Prairie, and within the Fairview district is presented. Also provided is a description of relevant socio-demographic characteristics of this community of approximately 8,200 residents.

21. Alcoholism: Strategies for Northern Alberta **(1983).**

Alcohol and drug abuse are identified as a major problem in the north. The report notes that in order to launch a successful attack on the problem, greater community awareness is needed. In addition, people with alcohol and drug problems do not readily make use of addiction services. A range and diversity of services are necessary with interagency coordination.

The report notes that there are few professionals with adequate knowledge to address the addiction problems. Special groups which the report noted include:

- young people who need to have non-alcoholic social and recreational alternatives
- elderly who may be addicted to or are taking too many prescription drugs
- native people whose cultural differences must be taken into account in strategies for dealing with the problem; "parachute services" will not be effective.

AADAC was viewed as a welcome service in the north. The report states the need for AADAC to develop an overall strategy for the north and funding to match their mandate.

Recommendations:

1. **Development of a northern Alberta strategy for addictions**

   Adopt the report *Alcoholism: Strategies for Northern Alberta* as a guide for overall AADAC strategy for service delivery.

2. **Public education, awareness and support**

   Expand citizen awareness, education and media programs which are relevant to the social and economic circumstances in the north. School divisions to implement programs.

3. **Treatment services**

   Improve and expand existing and establish new treatment services in the north. Encourage all service agencies to review their role in addiction services.

4. **Coordination of services**

   Improve coordination, establish agency or interagency bodies.

5. **Professional education**

   Improve in-service addiction training by AADAC, professional associations and government.

6. **Staff recruitment and retention**

   Revise hiring practices by AADAC.

22. Family Violence in Northern Alberta **(1988).**

Issues:

The special conditions which make the north unique and deserve special attention in developing solutions are as follows:

- Isolation:
  - Some areas are several hundred km from the nearest centre or town and/or may only be accessible by air. The family is often the main source of support and victims may not be aware of services.
  - Social and emotional isolation are also of concern. Neighbours are either nonexistent or are reluctant to become involved.
- There are few options for a battered person in an isolated setting.
- Poor transportation connections:
  - Often public transportation is unheard of or is difficult to access.
  - If an area is only accessible by air, this severely limits the victims' options.
- Less extensive services:
  - With the low population base it becomes difficult to justify certain programs and services. Therefore the services are not there to turn to.
  - Services that do exist are underfunded, overextended and not readily accessible.
- Lack of anonymity results in an attitude of concealment.
- Safe shelter is difficult to arrange.
- Telephone service may not be available: may be a party line or may require long distance cost which can be a problem.
- Native concerns:
  - In the report *Native Women's Needs Assessment Survey* (1986), 63% of the women interviewed had been battered.

- These women are often far removed from information or services because of financial hardships and language and cultural differences.
- Problems of alcohol abuse, poverty and a number of family and social problems exacerbate the problem.

- Other reasons why natives may not use services which are available include:
  - unaware of services
  - reluctant to leave support of family and friends
  - socially pressured to remain in the relationship
  - uncomfortable with non-native counsellors or service providers
  - isolation, transportation and communication problems are also of concern.

Recommendations:

1. **Public awareness**

   Expand multi-media public awareness campaign.

2. **Regional coordinators**

   Regional coordinators in each of the two regions: northwest and northeast.

3. **Peace River Shelter**

   A shelter in the town of Peace River to serve the northern area of the northwest region.

4. **Satellite Shelters**

   Development of satellite shelters throughout the north.

5. **Longer-term Housing**

   Two-stage shelters in each region.

6-7. **Crisis Lines**

   An advisory body for crisis lines and a toll-free Zenith number for crisis line access.

8-9. **Batterers' Treatment Program**

   Maintenance and expansion of batterers' treatment programs and court-mandated treatment for batterers.

10. **Follow-up counselling and treatment programs**

   Provision of additional local counselling and treatment resources.

***23. Future Health Care in Northern Alberta: A Position Paper.* Presented to the Premier's Commission on Future Health Care for Albertans (1988).**

A detailed review of recommendations of the 23 NADC reports (or sponsored reports) which focused on health care was undertaken.

A significant fact uncovered in this review was that recommendations from a 1980 workshop on health needs in northern Alberta were still of issue in the 1988 review. The recommendations relevant to mental health include:

- Examine mechanisms to attract and retain health professionals in northern Alberta.
- Examine the role of specific services in the north, notably mental health, health care and small hospitals.
- Improve coordination among various providers.
- Consider establishment of a different health care delivery system.
- Implement preventive programs.
- Provide more service to isolated communities.

The report analyzed trends and their potential impact on northern Alberta from 1988 – 2008. Technological, economic, social and general trends are examined.

The major impact of technological advances will be in the areas of training of health care manpower, interagency communications, cost control and record keeping.

Increased economic development will put extra pressure on existing services and demands for services will increase.

The types of health care required will also be affected by increases in the native segment, single parent families, the aged, AIDS and STDs and sporadic boom situations.

General trends will have an impact in the conflict between public demand and ability to pay, transfer of responsibility for health care from the provider to the consumer and the need for government to explore alternative health care delivery systems which are more flexible.

Issues:

- Traditional health care delivery systems are not fulfilling the needs of the north.

- Recruitment/retention of health professionals is crucial.
- Fragmentation of present service is serious.
- Changing lifestyle demands more emphasis on prevention and personal self-care.
- Lack of resources/treatment in home communities.
- Strong need for increased mental health services.

Recommendations and Strategies:
Twelve recommendations in the categories of health care delivery system, recruitment and education of professional health care givers, health care services, communication, mental health and remote and isolated communities are presented.

1. Mental Health

Mental Health services should be upgraded and re-evaluated in northern Alberta.

Future philosophy of health care should be prevention-oriented and community-directed and active health campaigns and educational programs must be developed which promote a positive philosophy of prevention and well-being.

2. Health care delivery system

Development of a northern model which recognizes the unique requirements of northern areas and would include all institutional care, community health, occupational health, health care, and medical social services is recommended. Responsibility would be to provide health services, health-related prevention programs and fiscal and administrative responsibility.

3. Recruitment and education of professional health care-givers

Develop mechanisms to attract and retain staff.

Curriculum to include orientation to rural and northern practices should be put in place.

College of Physicians and Surgeons, AMA, AARN should support and encourage membership to locate in north.

Provide inservice and upgrading on a regular basis.

Family practice curriculum should include mandatory rural practice rotations.

A new kind of primary health care professional "from the north, trained in the north, for the north" should be encouraged.

4. Other

Mobile health care services should be developed.

Improved methods of communication among health care agencies should occur.

Special attention should be given to remote and isolated northern communities with an emphasis on preventive educational programs.

***24. Opportunities for Health Care Professionals in Northern Alberta* (1989).**

A community-by-community guide to health care opportunities in NADC boundaries. The focus is on health in general with no specific focus on any one area such as mental health. Very few mental health practitioners are noted in positions available.

(Focus is on institutions.)

25. Adult Literacy in Northern Alberta: Position Paper.

26. Adult Literacy in Northern Alberta: Background Report.

27. Adult Literacy in Northern Alberta: Statistical Report.

NADC undertook a review of the current state of literacy in the north and of all programs and practices addressing literacy.

The guiding principles suggested for development of programs to deal with literacy issues are applicable to the development of programs in any area including mental health. They are:

- Flexibility in timing and approach must be client-centred.
- Holistic — linking the client to the community in a meaningful way and recognizing all aspects of their lives.
- Accountability — clients need to take responsibility for their health and providers need to ensure that they are achieving results and making effective use of government dollars.
- Coordination — both at community and government levels; all service providers need

to work together to narrow the gaps between services.

***28. Employment Alternatives for Small, Remote Communities: High Prairie* (1985).**

The workshop held in High Prairie on January 11 and 12, 1985 brought together delegates from remote communities, government and industry. The purpose was to examine approaches to remote community development and economic development.

The remote communities in question (e.g., Peerless Lake, Conklin, Chipewyan Lake, Calling Lake, Trout Lake, Fort Chipewyan, Elizabeth Metis Settlement, Cadotte Lake and Atikameg) have had consistently high levels of unemployment which results in other problems.

NADC recognizes the need to help native people become more economically self-sufficient and to encourage the ongoing establishment of a system of local decision-making in Improvement Districts and remote communities.

Changes to traditional economies of trapping, hunting and fishing which continue with the increase in oil, gas and forestry activities result in social problems. These problems arise as a result of dependency on welfare and inability to access new employment.

A number of strategies aimed at increasing and improving employment opportunities were identified through the workshop. Strategies such as providing resources to allow the community to develop organizational skills with a long-term goal of managing the delivery of services themselves, and other community involvement strategies could be applicable to mental health service delivery.

29. Trends in Northern Alberta: 1970-1990.

Presents an information profile on northern Alberta.

- While communities feel independent and self-sufficient, they are dependent on external markets for economic viability.
- Rapid change — while new technologies and new ways of living are adopted, important "old ways" traditions are still retained.

***30. Ambulance Service in Northern Alberta.* Submitted to Minister's Policy Advisory Committee on Hospitals and Medical Care (1987).**

Position paper on ambulance service in northern Alberta.

Ambulance service is an integral part of an effective health care system and is seen as a priority for northern Alberta, because of distances and socio-economic factors in the north.

***31. Economic Development Opportunities in Northern Alberta: Overview Report* (1985).**

The report provides a summary of economic development issues and opportunities in northern Alberta based on interviews, seminars and community workshops with business, industry, community and government representatives.

Important findings to note include:

- Northern residents want long-term economic stability and diversification for their region in order to encourage young people to stay in northern Alberta.
- With the ongoing expansion the need for improved health care cannot be ignored.

***32. Human Services in Wabasca/Desmarais: A Review*. Peekiskwetan Society. Bairstow and Associates Consulting Ltd. (1989).**

As a result of a June 1983 request for a permanent multi-purpose emergency shelter for the community of Wabasca/Desmarais, a study of the human and crisis needs of the community was undertaken. The study was conducted in 1984.

Objectives of the study were to:

- describe the community's human and crisis needs
- inventory human service delivery systems
- identify and analyze service gaps and delivery problems
- develop a community-based strategy to resolve major issues
- review the need for specific services such as the proposed shelter.

Thirty-one previous studies were examined. Common themes were expressed in each study report. Issues which arose from individual inter-

views with agency staff and from an interagency workshop include:

- Lack of coordination; no regular effective way for agencies to coordinate their services delivery.
- Serious lack of good statistics on clients needs; inadequate information about actual need.
- Problems of linking clients to services; transportation problems and not keeping appointments.
- Follow-up with clients and case management do not exist.
- Difficulty in recruiting qualified staff.
- Politics are a negative factor; internal conflict between the two communities; Bigstone Band reluctant to work with off-reserve agencies.
- No real effective local government.

A number of criteria for successful solutions were proposed. These include:

- recognizing the constraints facing existing agencies and services in terms of budget, staffing and workload
- involving all agencies in a cooperative effort rather than having one agency take on the role
- focusing on gaps, rather than identifying problems, on solutions, and on prevention and early intervention and thus reducing the need for crisis intervention
- addressing fundamental social issues that lead to problems (e.g., alcohol, lack of jobs)
- improving collection of data on need.

Several recommendations are presented relating to medical services, mental health services, program coordination, housing and educational services, and employment and training services.

The recommendations for mental health services are for a full-time qualified resident mental health worker or psychiatric social worker to be available to provide counselling services in the area.

Areas of concern are:
- suicide
- sexual abuse
- battering
- alcoholism and other family problems.

A 24-hour crisis hot-line managed by the community and a system for referring cases to appropriate services in Grande Prairie are also recommended.

Other relevant recommendations include those which call for coordination of all programs and services in the area and making the community, both service providers and consumers, aware of the services and programs in the area. School counselling and employment training which recognize some of the existing social problems are also recommended.

33. Preliminary Evaluation of the Slave Lake, Alberta, Crisis Initiated Brief Interventions Project. **Alberta Health — Mental Health Division; North West Rural Team (1989).**

The report identified the need for a crisis initiated brief intervention (CIBI) focus for AMHS in the Slave Lake area. Rates of suicide and violence reported in northern Alberta supported the need for crisis counselling programs. Human service agencies in and around Slave Lake were optimistic about, responsive to, and cooperative with the new focus for mental health in the area.

The major drawback was that clients not in crisis were refused service or referred elsewhere. The intention of encouraging development of alternative sources like private practitioners and local clergy and other agencies to take on counselling low priority cases had yet to be developed.

34. Early School Leavers in Northern Alberta: Workshop Report.

35. Early School Leavers in Northern Alberta: Technical Report.

36. Early School Leavers in Northern Alberta: Summary Report. **HLA Consultants; for NADC and Alberta Education, Northland School Division (1984).**

The objectives of this study were to examine the situation of and the extent of the early school leavers in northern Alberta and to develop and recommend a monitoring system for students, and practical and realistic measures to reduce the incidence.

Among the variables noted as having an influence on early school leavers were home life and social factors such as drugs, alcohol and pregnancy. As

such, some of the recommendations point to the need to develop relevant support programs such as career and guidance counselling; identification of the at-risk student and provision of life skills for these students.

A parallel can be drawn between the issues regarding teachers in this study and mental health professional and non-professional workers. The need for continuous upgrading of teachers; teachers better prepared to teach in a cross-cultural setting and in a geographical situation are applicable to the delivery of mental health services. Strategies for achieving this include an increased emphasis on cultural awareness in teacher training and making education students aware of the options.

Finally recommendations concerning the need to modify the administration of the education system to better meet local conditions and the involvement of the community in directing provision of education could apply to mental health service delivery.

The Technical Report provides detailed presentation of recommended mitigative measures and supporting rationale, literature review and detailed discussion of study methodology; data and analysis.

37. Whitecourt Growth Impact Study. Part 1: Background and Technical Report. **Transition Management Ltd. and Kinnaird Planning and Research Ltd. (1989).**

38. Whitecourt Growth Impact Study. Part 2: Action Plan. **Transition Management Ltd. and Kinnaird Planning and Research Ltd. (1989).**

Part 1 — Background and Technical Report
Presents background information, demonstration and labor force data and perceptions and opinions of human responsive and business related services within the town.

Part 2 — Action Plan
The key findings of the study were:

- A 22% increase in population is estimated for 1989-1993.
- There is a high concentration of people 18-24.
- Over 80% of residents think Whitecourt is a friendly place to live.
- Unemployment rate is below provincial average.
- Labor market is "thin" (not many people).
- Town is generally well served by existing infrastructure, although hospital and fire protection are deficient.

The principal outcomes of the study are:

1. an information base designed to assist service providers
2. an action plan and recommendations to address the strategic and service issues which the town must consider in planning for orderly growth and development.

The study recommendations are developed using an integrative approach where all factors which affect quality-of-life are considered together.

Specific recommendations concerning social services/family and community support services (FCSS) include:

- improved dialogue between interagency group and business community with the goal of promoting a strong quality of life
- increased communication and awareness about available services
- service providers to address issues such as gaps in counselling needs (mental health, family) handicapped services and native issues.

39. A New Beginning: A Review of the Needs of Seniors in the Peace River Health Unit **(1986).**

Group — Regional Interdisciplinary Steering Committee for Geriatric Services in North Peace River Region.

Issues:

- Northern seniors face same problems as others but these are often more severe because of distance and isolation.
- They face relocation to strange community when hospitalized.
- Home Care programs in the north are extremely expensive because of dispersed population and need for more extensive travel.
- What works in urban settings often doesn't work in the north.
- Agency interviews highlighted the need for better liaison between mental health services and area hospitals and that no specialized

mental health services for the elderly exist in the entire Peace region.

Conclusions from the survey of agencies and seniors included the following:

- Support groups etc. aimed at the bereaved, and other losses due to aging are needed.
- Low literacy rates and lack of fluency in English needs to be considered in making decisions about communicating information.
- Seniors should be involved in planning services which affect them.

Recommendations:

- that service providers coordinate their activities, share information and involve seniors
- that programming be flexible to meet local needs and that local input be considered in planning
- that the role and operation of senior citizen centres be redefined to meet the broader needs of the community and to become focal points for programming and information dissemination
- that support provided by families be encouraged and enhanced through respite services.

40. Community Mental Health Needs Assessment Report and Recommendations. **Lesser Slave Lake Indian Regional Council (1984).**

A research project was undertaken in an attempt to assess the counselling and mental health services of the Indian communities under Lesser Slave Lake Indian Regional Council (LSLIRC); identify resources available to communities, gaps in service and barriers to service; assess spiritual and emotional needs and make recommendations for future program planning.

A definition of mental health is not provided but a holistic definition of health is presented as a balance between body-mind-spirit and the environment, and coping with stress within ourselves, families and communities.

A needs assessment survey including community interviews, fieldworker questionnaires, key informant interviews, and agency interviews was undertaken. Recommendations resulting from the assessment include:

- Mental Wellness program — to be established on each of the nine reserves and designed to meet the unique needs of each rather than provide the same service to every community and should develop in a complementary manner to existing services. The program should examine the use of traditional basic counselling approaches.
- Provision of a range of mental health services to include consultation, education, referral, counselling and research.
- Program coordinator.
- Coordination with neighboring communities — program coordinator should be involved in other program services provided in High Prairie and Grande Prairie.
- Expansion of mental health services by Medical Services Branch.
- Expansion of staff resources.
- Training of staff.

The Meyohkesehgow Program

The LSLIRC initiated a small community-based counselling program which provided education, counselling, consultation and research. Some of the problems encountered in providing service were:

- distance factor in providing care to all reserves
- caseload restraints due to manpower limits
- maintaining continuity of care when person entered a general hospital out of council area
- difficulty in differentiating between responsibility by NNADAP or the program in question for alcohol-related problems
- inadequate number of NNADAP and other alcohol fieldworkers
- inadequate office space to provide confidential counselling.

41. Beaverlodge Community Survey. **Dr. George Kupfer; Fresh Start Social Consultants (1985).**

The report presents a model for undertaking a community-initiated and managed needs assessment study. It demonstrates that citizens can act on their own behalf using local initiative.

The study categorized and focused on community programs, health care services and use of existing recreational/cultural facilities and programs. The need for mental health services was identified by 47% of respondents. Marriage counselling, alcohol and drug counselling were also seen as needs.

***42. Community Needs Assessment Survey.* Town of Grande Cache (1987).**

Results of the Community Needs Assessment Survey are presented. Issues and recommendations are not presented.

Of those surveyed, 58% were aware of the mental health office in Grande Cache which provides counselling free of charge. Over 95% of respondents thought that Grande Cache required counselling services in the areas of:

- marriage and family conflicts
- depression and suicide
- sexual and marriage problems
- assertiveness and life skills
- adolescent problems.

***43. An Analysis of the Local Roads Problem in the Elk Point Lindbergh Field Oil Sands Development Area* (1985).**

Although this report focuses on the problem of maintaining adequate road conditions in the area of the oil fields, it supports the issue of transportation as identified by other briefs submitted to NADC. Further, it points to the problems or potential problems caused by rapid industry development in a rural area.

***44. Red Earth and Area Health Facility Study.* R. Harman and Associates Ltd. (1988).**

The communities of Red Earth, Loon Lake, Trout Lake and Peerless Lake need a comprehensive, integrated health care and community service. Health service of any kind is sporadically available. No mental health services are provided, although with increased oil field activity in the area, "community health problems" are on the increase (e.g., alcohol and drug related problems, suicide). Specific mention is not made of mental health professionals.

It is recommended that an attempt be made to establish visiting services from various health professionals.

***45. Fairview College's Northern Region Adult Literacy Program: the Impact of Literacy on the Lives of Students and Tutors.* Daina A. Bruners and Associates (Sponsored by Fairview College, North Region and NADC).**

The main objective of the study was to determine if the literacy program at Fairview College had made a difference in the lives of students and the tutors. The result showed that a number of positive changes had occurred. The biggest change was the increase in skill and self-confidence which led to the development of valuable employment-related skills. This had carryover benefit for the communities.

46. Mental Health Services in Alberta: Sharing a Vision of Better Health. **Alberta Health (1988).**

This report provides overall policy direction to guide program development for mental health services in Alberta. The principles proposed include the following:

- Effective mental health services require partnership among the family, community and government.
- Continuum of services as resources permit should be available.
- System should maintain and strengthen individual, family and community resources and should facilitate independence and respect personal lifestyle.
- Should provide least intrusive service possible and where intrusive service is needed, the goal should be to return to less intrusive levels as soon as possible.
- Should foster self-sufficiency.

Model:
The model proposed in the report addresses seven needs or issues:

1. continuum of care
2. coordination
3. overall service priorities and corresponding allocation of resources
4. prevention and promotion
5. multidisciplinary approach
6. sharing of information
7. unique needs of special groups.

The five components of the model range from preventive programs, community support, community services, treatment services, inpatient care to long-term inpatient care. The intent is that entry to each of the components requires satisfaction of more stringent criteria. This is meant to promote the use of the least intrusive service available.

The model also considers the geographical configuration of Alberta and proposes a different level of services provision for urban, regional and rural areas. Rural areas should have access to generic or basic services which include access to a mental health worker, a physician and a general hospital.

Issues, Goals and Proposed Actions:
The goals and proposed actions which are most relevant to mental health services in the north are as follows:

- Continuum of care — to increase the range of community services; encourage hospitals to become involved in providing community-based programs; and fund community agencies to provide services which are responsive to local needs.
- Service coordination — improve coordination among service providers and make use of existing coordination mechanisms; require that regional psychiatric services planning committees be involved in planning for services in their own areas.
- Service priorities and allocation of resources — to clarify expected levels of service provision according to geographical location.
- Prevention and mental health promotion — increase support for development and provision of prevention and health promotion programs for the general population and develop prevention programs targeted for special needs groups.
- Staffing and recruitment — encourage universities and other post-secondary institutions to incorporate mental health training in the curricula; develop effective recruitment strategies and increase use of consulting psychiatrists in rural areas.
- Information systems — work toward facilitating integration and sharing of information.
- Services for special groups — provide quality generic mental health services which recognize special needs within the general delivery system.

47. Claiming My Future: A Person with a Mental Disability — Today & Tomorrow. **The Brassard Committee Report (1989).**

The report examines the current service provision system for persons with a mental disability and makes recommendations for expanding community-based services for this group. A definition of mentally disabled is not included in the report.

Deinstitutionalization and empowerment of the client are key recommendations.

***48. Exploring the Circle: A Journey into Native Children's Mental Health.* Murray Armstrong, Alberta Children's Mental Health Project. Alberta Social Services and Community Health (1986).**

This document is a follow-up to *Expanding the Circle: A Community Approach to Children's Mental Health.* It is an attempt to outline and demonstrate the uniqueness of native children and the need for a specialized native children's mental health service. It is their belief that ". . . mental health of native children, families and their communities depends on the ability of native and non-native people to work together towards a 'mental health service' that truly meets the needs of native children rather than one reflective of a dominant society's view of what is needed."

Issues Identified:
The report outlines a number of factors related to Alberta's native population, including historical factors; cultural factors; value differences; tribal and regional differences; status differences; native organizations; urbanization and biological issues. These factors must be acknowledged in examining services for natives.

The report also presents other issues and/or strategies specific to the "native situation." Needs assessment for example must be community-based, holistic and very culturally attuned. This process must move slowly and be of high quality. These issues, etc., would be useful to consider when looking at service involving natives, not exclusively native children. Jurisdictional issues surrounding service provision to natives are identified.

Solutions Proposed:
Strategies suggested by native people for a native children's mental health service are that the service must be:

- community-based
- educationally based, including parents and care givers; children and adolescents and community education and awareness programs
- preventive
- holistic
- able to incorporate significant native input at all levels.

Comments:
The conclusion of the report is that mental health services to all native people is a provincial responsibility; therefore, a mandate must be included in provincial legislation. The legal mandate for native services could be included and subsumed under legislation pertaining to children's mental health services. Specific recommendations are for the establishment of:

- a position paper entitled the Coordinator of Native Children's Mental Health
- a team responsible for the development, implementation and evaluation of a native children's mental health service
- cross-jurisdictional mechanisms for communication, collaboration and coordination
- linkages with community-based native and non-native services, including a carefully planned cross-cultural staff-training process for present and future staff
- regional positions whose responsibility would be to collect information and coordinate regional endeavors.

***49. Expanding the Circle: A Community Approach to Children's Mental Health.* Gerry Fewster, Alberta Children's Mental Health Project. Alberta Social Services and Community Health (1986).**

The purpose of this document is to promote discussion of children's mental health as a provincial concern; not just an issue of service delivery, but as an issue of concern for all individuals and groups in all sectors of the community. The position presented in the report is that children's mental health service should be delivered within a broad framework which promotes mental health of children through families, schools and communities; that responsibility belongs to communities not professionals who serve them; promotes prevention and proposes that needs and services should be identified through consumer and community initiatives rather than expert enlightenment.

Main Principles Proposed:
1. Children and adolescents require a separate system of mental health services that addresses developmental needs.
2. Services should operate in support of the

normative developmental, cultural, familial and community processes.

3. The focus should be upon mental health, rather than ill-health.

4. Mental health is a subjective experience rather than an ascribed state.

5. Individual treatment is only one aspect of a comprehensive mental health system.

6. Treatment (as defined) should be the exclusive responsibility of the designated mental health service.

7. The overall objective is to enhance the psychological well-being of children and adolescents in accordance with an agreed upon set of community standards.

8. Service consumers should be "empowered" with options and financial resources.

9. The system should operate in support of primary care givers rather than assume this role.

10. Services should be based upon needs identified within the context of the community.

11. A high priority should be given to strategies of education and prevention.

12. The community should be viewed as a primary resource and the ultimate area of accountability.

13. The system should be negotiated with communities, service providers and jurisdictional planners in accordance with agreed upon principles.

14. Responsibility for establishing and maintaining standards should be clearly assigned to the mandated children's mental health jurisdiction.

15. Universality of access should be assured.

16. Adequate provision should be made for children and adolescents with special needs.

17. Native children and families should have access to the system in general with special provisions addressing cultural diversity.

The issues for Alberta are:

- System is reactive rather than proactive.
- Lack of a coherent approach to the provision of mental health services for children, adolescents and their families. With limited resources, no unifying philosophy or policy and little cross-jurisdictional coordination can exist. This puts pressure on each service provider to deal with the most urgent needs, typically those experiencing a problem or illness, while the health promotion and prevention approach is pushed aside.
- With a concentration on current caseloads little effort is put into identifying need for promotion and prevention activities. Without an identified need, requests for these programs receive little attention.
- A change in attitude/thinking is required; more resources to fill the gaps will not suffice; what is needed is a restructured preventive community-based approach.
- Although resources are generally thought to be in short supply, it is not clear what the true picture is. In addition, the most essential resource — the community — remains largely unexplored.

Recommendations:
Key to the recommendations is the need for a grass-roots approach to identify need and develop a workable system.

Alberta Mental Health should be given a new mandate for children, adolescents and their families; a mandate which crosses departmental jurisdiction. Specifically:

1. The establishment of clear criteria and standards for the operation of children's mental health programs.
2. The provision of a wide range of educational, preventive, assessment and treatment services in each region of the province.
3. The establishment of a clear mandate to initiate, coordinate, monitor and operate educational and preventive community-based strategies.
4. The establishment of cross-jurisdictional mechanisms for communication, collaboration and coordination.
5. The establishment of effective mechanisms for community involvement and participation.
6. Ultimate responsibility for ensuring that the mental health needs of children, adolescents and families are being adequately addressed in each region of the province.

Solutions Proposed:
1. Establish joint policy and planning activities.
2. Develop a legal and operational mandate for Alberta Mental Health Services.
3. Establish a clearly differentiated component for

children's mental health services at both the provincial and regional levels.

4. Establish information centres in each region of the province.
5. Negotiate the delivery of children's mental health services with the Department of Social Services.
6. Develop a strategy for serving native peoples.

50. A New Vision for Long Term Care: Meeting the Need. **The Mirosh Report. Alberta Health (1988).**

The report focuses on the impact of changes in the demographic, social and health care environment over the next two decades (up to 2010) on the long-term care system. recommendations which are relevant to mental health services delivery are those which call for development of public education and health promotion programs for enhancement of the health status of seniors; expansion of day programs and respite care; recognition of specialized care for those with psychogeriatric problems and for education of professionals in the needs of the elderly.

51. Recent Trends in Outpatient Services to Priority Client Groups. **Mental Health Division, Alberta Health (Revised, 1988).**

Four priority groups identified for Mental Health Services are:

1. children
2. elderly
3. chronics
4. rural residents.

In 1986/87 and 1987/88, three diagnostic groups: (1) clinical depression; (2) family/psychosocial problems and (3) adjustment reactions/reaction to stress, accounted for 75% of rural residents caseloads. Anxiety disorders represent 44% of the rural caseload.

According to Mental Health Services' definition of rural, all of the NADC area residents except for residents of Grande Prairie and Fort McMurray are considered rural. Those clients who are either chronics, elderly or children are excluded from the rural category.

52. Changing Thinking and Thinking Change. **Mental Health Strategic Planning Forum Group (1989).**

The forum was sponsored by the Premier's Commission on Future Health Care for Albertans, Premier's Council on the Status of Persons with Disabilities, Provincial Mental Health Advisory Council, Alberta Health, CMHA, and Alberta Friends of Schizophrenics.

The forum involved 20 groups including mental health service providers, consumers and advocates.

Issues Identified:

- Service availability including the absence of community-based services; services in rural areas and services for special groups such as natives, children and elderly.
- No continuum of care.
- Service fragmentation and lack of coordination.
- Funding issues, including funding "to fit the individual".
- Availability and expertise of care givers including need for more resources particularly in rural areas, specialized training and training for "natural care givers".
- Adequacy of support services particularly for care givers.
- Underdeveloped role of family and advocates.
- Lack of client involvement, consumer empowerment in decision-making affecting them.
- Need for more education and attitude change.
- Absence of prevention and early intervention.
- Need for legislation which protects individual rights and assures comprehensive and coordinated services.
- Confusion regarding models, values, terminology including medical versus holistic model, illness versus health, client versus provider orientation, meaning of community.

Proposed Strategies:

Two strategies which received the most support by the forum were:

1. Development of local and regional authorities to ensure appropriate entry, continuity of care and case management. The regional board/ authority would have funding authority. Sug-

gestions were made to expand and strengthen psychiatric services planning committees to undertake this role.

2. Commitment from government to undertake massive mental health education campaign in day care, schools and other locations. Role of mental health professionals and advocacy groups as educators in the community should be increased.

Other strategies proposed include:

Provincial Level
- creation of a provincial mental health institute
- development of a comprehensive Mental Health Services Act
- education and training of providers in holistic approaches
- funding of research to reduce need for future mental health services
- more equitable funding for mental health system
- provincial mission statement which recognizes values and principles.

Local level
- single point of entry
- consumer advisory boards
- mission statements for each service
- improved communication about mental health issues with media, care givers, consumers, families, politicians.

Values and Principles:
- least intrusive care, individualized with the focus on the client
- choices
- availability and accessibility
- comprehensive system
- recognition of and support for importance of the family
- resources that follow the individual
- empowerment of consumers and providers
- services that are accountable.

***53. Mental Health in Alberta: I. Philosophical Issues.* A. H. Thompson and C. A. Roberts — Draft.**

Treatment of mental illness/disorder must be accompanied by efforts to reduce social problems, stress factors in society. The paper discusses the following:

- Prevalence rates of around 17.1% for mentally disabled are not only stable across age groups but across geographical regions and time as well. Use of mental health services has been found to be related to variables such as type of disorder, severity of symptoms, care giver's education, health and perception of disorder and geographic area.
- Alberta has a high rate of social problems as shown in a recent study by Thompson and Howard (1988); *Mental Illness and Social Problems*.
- Data indicate that social problems and mental disorder are highly positively correlated.
- Given the evidence of a strong association across individuals between social problems and mental illness, the hypothesis put forth is that social structure and mental illness rates interact to produce social problems. That is, communities with a high degree of disorganization are more likely to produce the conditions necessary to allow potential mental illness to surface. Thus "social structure" would not "cause" mental illness but would interact with existing levels of mental illness in the population to produce social problem behavior.

Solutions Proposed:
Strategies to deal with the Alberta situation include:

- Continued effort to provide the best treatment services for those with early signs of mental illness and mental health problems
- Focus on basic societal structures such as strengthening communities and families to help prevent the manifestations of social and mental health problems.

Recommendation:
It was recommended that significant resources be allocated for the:
- establishment of a strategic planning group to

develop an approach for strengthening families and communities
- research capability to support planning efforts
- continued research into treatment strategies, but no additional funds for expansion of treatment services.

54. Mental Health in Alberta II: the Present Mental Health Care System. **Thompson and Roberts — Draft.**

The paper outlines the current system of mental health care in Alberta and identifies issues related to the delivery of effective and efficient mental health care through this system. The system includes formal providers: those with a primary responsibility for provision of mental health services (e.g., hospital, community mental health clinics) and informal providers: those which influence the mental health of Albertans (e.g., education and public health).

Issues Identified:
- 88% of funding goes to institutional care with 31.4% of that going to community caseloads and 68.6% to mental health caseloads.
- Approximately 1/3 of mental health clients are receiving 90% of the total budget.
- The trend or philosophy for more community-based care has not been matched with the appropriate allocation of money.
- Expertise and training of community-based resources: Clients do not have access to trained professionals (psychologists) and therefore get service from untrained (practitioners) because of the difference in coverage under AHCIP.
- No compensation for practitioners to provide consultation to other community resources (e.g., psychiatrists to consult with doctor, clergy, nurses, counsellors). This is especially relevant to the north.
- Specialized mental health practitioners (psychologists, social workers, psychiatrists) cluster in the urban areas (87% are in Edmonton and Calgary). Very few (6%) are in rural areas. The consequence is that clients from non-serviced areas must travel or relocate to urban centres (away from home, families, social support systems) for service.
- Problems with inability of current system to self-correct include:
  - difficulty in developing comprehensive strategic plan for mental health services as a whole due to the structural and functional boundaries which exist between programs
  - barriers related to funding make the shift to the community particularly difficult
  - lack of incentives for efficient delivery of service; resources could be used more efficiently in the community.

Recommendations:
1. The structure of the formal mental health system should be modified to allow for movement of resources as needed, allowing the system to self-correct.
2. Review funding with a goal of promoting and rewarding efficiencies, not inefficiencies.
3. Further develop community mental health services (Sharing a Vision).
4. Study and resolve problems of rural communities in recruiting qualified mental health personnel (added money incentive).
5. Cover clinical psychologists by the payment scheme; create specialty designation "Clinical Psychologist" and develop an accredited Clinical Psychology Training Program in Alberta.
6. As above, access to social workers should be guaranteed.
7. Adjust fee structure to allow for consultation services by mental health professionals.

55. Mental Health in Alberta III: Mental Health Promotion and Innovative Strategies. **Thompson and Roberts — Draft.**

Paper presents strategies and innovative programs of mental health promotion and mental health care in Alberta.

Solutions Proposed:
1. Strategies for mental health promotion and innovative programming:
   - Undertake a comprehensive review with the goal of recommending specific strategies for mental health promotion, prevention, innovative treatment programs and implementation plans.

2. Community stability and support:
   - Indications are that certain community structures are more conducive to emotional stability and produce fewer social problems.
   - A task force of community members across Alberta should examine this issue.
3. Deinstitutionalization:
   - Renewed commitment to the development of community mental health services with mechanisms to allocate the necessary funds.
4. Early identification and intervention/implementation:
   - Public education on early signs, symptoms and resources should be undertaken.
   - Public health system would serve as an ideal "agency" for early detection of childhood and family difficulties.
   - Establish child welfare wards.
5. Mental Health consultation model:
   - Develop mechanisms which promote, facilitate and financially support a mental health consultation model so that the network of professionals who provide treatment is expanded.
6. Development of individual coping skills:
   - Adopt and implement strategies for teaching improved problem solving and social skills to children through school systems, day cares, public education and work with families.
7. Employee assistance programs:
   - Develop/expand employee assistance programs in Alberta.
8. Placement of Mental Health professionals in Medical Clinics:
   - Undertake a study to develop a model for collaborative interventions between physicians and mental health practitioners at the medical clinic level.
9. Native mental health:
   - Government of Alberta should provide support in fostering the native community's move toward community independence.
10. Relationship between mental well-being and physical health:
    - Undertake further research in the links between mental and physical health and use findings to develop innovative programs for promotion of mental health.
11. Children's mental health:
    - Develop a children's mental health system to include prevention; promotion; early identification and treatment.
12. Research:
    - Continue and expand quality research.

56. Senior Independence Program: Minburn-Vermilion Health Unit. **Robert W. Cameron, President, Home At Last Ltd. (1988).**

Program was developed to increase the capacity of persons over 65 years to remain in the community and to decrease the need for institutionalization. Program goals are to:

- identify seniors most at-risk of being socially isolated
- connect seniors to available community resources
- promote programming that enables seniors to develop their own resources and support networks
- increase community awareness of needs of seniors
- create a self-funding mechanism for program operation.

The program uses a model whereby the professionals act as a catalyst to help the elderly increase their ability to remain in control of their own well-being and health.

The program model could be used for health promotion with other target groups in the area of mental health.

57. Sharing Solutions: Toward a Master Plan for Service Delivery to the Mentally Ill. **A Joint Workshop on Mental Health Service Delivery in Northern Alberta (1989).**

The purpose of the workshop was to develop long- and short-range solutions to address current issues and existing shortcomings in the delivery of services to the mentally ill in northern Alberta.

Objectives were to bring together a broad range of people with mental health experiences (consumers, care givers and planners); focus on solutions to issues in care delivery system and provide a

nonpartisan opportunity to discuss solutions and develop implementation plans.

The first part of the workshop featured presentations by speakers knowledgeable in mental health issues in northern Alberta. The major portion of the workshop was an exercise in planning. Each of three groups was given the task of developing a master plan for mental health service delivery in northern Alberta.

Three proposals are presented in the report. They each show some major similarities in philosophy and structure but differ in many details. All groups feel that the path to improved service is through better service coordination and integration.

Two main themes are common to all models:

1. A single authority for all mental health services: Each proposal suggests the formation of a mental health commission to fulfill the role of the single authority.
2. Local mental health authorities: Regional boards are proposed as the vehicle to meet this function.

All groups agreed that key components of the system would include community mental health clinics, psychiatric inpatient services, day programming, case management, crisis services, housing services and vocational rehabilitation. Other components would vary according to local needs.

One group suggested a single entry system for persons in need of mental health care. Other areas where the groups did not all agree were boundaries, mental health promotion and illness prevention, need for research, evaluation and information systems.

***58. The Rainbow Report: Our Vision for Health.* Premier's Commission on Future Health Care for Albertans. Final Report (1989).**

The report proposes twenty-one (21) groups of recommendations. Six directions for changes have been selected from those recommendations.

Specific to mental health, the report states that "attempts have been made to move people with mental illness from institutions into the community where — without adequate preparation or support mechanisms — they are confronted with multiple hurdles before they can obtain the required support services."

The report notes that their definition of "community" is a sense of belonging. They suggest that Alberta should look at the Dane County (Madison, Wisconsin) model as one of North America's most highly-reputed community support programs for persons with mental illness.

It is noted that the commission heard from professionals and consumers who both stated that funding is heavily biased toward institutional care, even though in reality the majority of clients receiving services do so in the community, and, philosophically, they should not receive treatment in institutions.

The commission urges that the role of the newly appointed Mental Health Advocate be reviewed and expanded to include not only formal patients, but also persons in the community. They also note that 96% of private mental health professionals live and work in the cities of Alberta, and that Albertans living in rural areas who require specialized services have to either relocate to these urban centres or go without treatment. The natural supports in the rural areas need to be sustained.

People who spoke with the commission asked for a more coordinated approach to mental health policies, programs and regional services. They believed that "mental health services and health promotion activities are strengthened when those whom they are intended to benefit participate in their design and implementation." They also requested more education and mental health promotion on how community life can be improved, mental well-being enhanced and social problems reduced.

They also noted that early identification and intervention would help communities to deal more effectively with mental health needs. A major topic of discussion at a conference of providers and consumers (Sharing Solutions?) was the integration of mental health and illness approaches with physical health and illness, such as currently occurs to a variable extent in general hospitals. This would reduce the stigma associated with mental illness which isolation in institutions serves to exacerbate.

The recommendation for nine health regions may also be crucial to recommendations for changes to the mental health delivery system in northern Alberta.

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Appendix C
Innovative Service Coordination Projects in Northern Alberta

Innovative Service Coordination Projects in Northern Alberta

Spectrum

The Spectrum program is mandated to develop a mental health service delivery network for Grande Prairie and area. It is managed by the Grande Prairie Interdepartmental Psychiatric Planning Committee, which includes representatives from AADAC, Alberta Health, Alberta Mental Health, Alberta Family and Social Services, the Canadian Mental Health Association, Family & Community Support Services, the Solicitor General, the Queen Elizabeth II Hospital, and the South Peace Health Unit. The program is funded by Alberta Health through provisions to Alberta Mental Health and the Queen Elizabeth II Hospital.

Spectrum was established in 1989 to address mental health service delivery concerns including long waiting lists, limited resources, lack of coordination, difficulties in sharing client information, and difficulty accessing a continuum of services. It is a single point of entry system that incorporates intake, information, assessment, referral, crisis management, follow-up, and evaluation. Additionally, the program works with the providers of mental health services to identify service gaps and duplication. One of its first activities was to determine the patterns of service delivery and a data base of mental health resources in the area (see, *Spectrum: Service Delivery Patterns, Mental Health Services, Grande Prairie and Area.* 1989). Staffing includes a project director, a team leader, two intake workers, and a case aide.

Consumers are accepted on a walk-in basis or through referral from community agencies, institutions, physicians, family members, etc. There are no restrictions in age, gender, or presenting problems; however, referral to and acceptance by community agencies is contingent upon the consumer meeting the entry criteria for the specific agency. Following intake and assessment, a treatment plan is developed through case conferencing with assessment team members and representatives from participating service agencies. The case conference is the primary coordinating mechanism within the Spectrum model. The program also includes post-discharge follow-ups at three and six months to assess consumer satisfaction with the system and with the services provided.

Although the program is just getting off the ground, it is being enthusiastically received by service providers and consumers alike in the Grande Prairie area. We understand, however, that a satisfactory relationship between the program and the hospital has yet to be worked out.

Venture

The Venture program is an innovative project developed to facilitate cooperation and collaboration between services providers. It began in late 1988 as an agreement between two principal service providers, the Fort McMurray Regional Hospital and Alberta Mental Health Services, to collaborate and develop an effective in-patient/out-patient program for mental health patients in the Fort McMurray area. It is funded by Alberta Health through provisions to Alberta Mental Health Services and the Fort McMurray Regional Hospital.

Following the establishment of the Fort McMurray Regional Psychiatric Services Planning Committee in 1984, information sharing among service providers was encouraged, leading to discussions of a joint venture between Mental Health Services and the hospital. The resulting Venture program not only provides for a communication network between service providers but also involves sharing of staff in the provision of these services.

A day program, jointly run by Mental Health Clinic and hospital staff that involves a four-week group therapy program, among other activities is a significant component of Venture. Some other highlights of the collaborative effort include:

- agreement between the hospital and Mental Health Services to insure free exchange of information concerning patients
- regular case conferencing between hospital and Mental Health staff
- agreement that any planning or development involving in-patient or out-patient programs be conducted on a collaborative basis between Alberta Mental Health and the hospital

- multiple points of entry with a single assessment.

Clients are referred to the program by agencies, doctors, parents, or through self-referrals. Upon intake, the client is screened and, if appropriate, assessed by Venture staff therapists. Following a recommendation for treatment, a case conference between staff is undertaken. Available services range from individual psychotherapy (clinic or hospital), to group family therapy (clinic or hospital), to in-patient services (hospital). Case management resides with the original therapist throughout the course of treatment.

Venture has been well received by community agencies and consumers in the Fort McMurray area, and it continues to build and extend the concept of a continuum of care for mental health clients by including a wider range of services.

Insight

Insight is the most recent innovative service coordination program in the north. It is more similar to Venture than to Spectrum in that it is based primarily on an agreement between Alberta Mental Health and the St. Theresa General Hospital in St. Paul. A single assessment, joint case conferencing and a communication network are the bases of Insight. Options such as shared day programs and involvement of other agencies are yet to be developed.

Northeast Region Children's Mental Health Services Pilot Project

This pilot project, initiated March 1987, is scheduled to operate until March 1991, at which time a decision to make it permanent is to be made following an evaluation of its effectiveness. The evaluation has been completed. However, it had not been released at time of writing.

The pilot project is an agreement between the Northeast Region of Alberta Mental Health and Alberta Social Services (now Alberta Family & Social Services), enabling Mental Health and Child Welfare to work together and combine their resources. Its purpose is to improve mental health services to children in the region, especially those in need of protection services, and to serve a preventive purpose for Child Welfare by forestalling the need for certain children to receive protection services. The project is administered and supervised by the Northeast Region of Mental Health Services.

Services covered by the agreement include:

- consultation
- assessments
- diagnosis
- design of treatment plans
- prescription and administration of medication
- individual therapy
- group therapy
- family therapy where required as part of the program of treatment for a child
- post-treatment monitoring and follow-through
- mental health education and other prevention programs.

Workshops have been conducted with service providers to clarify the goals and objectives of the project, and case conferencing is used extensively.

It is our understanding that the agreement has been living up to expectation in many communities in the region. In others, such as Lac La Biche, where the position of mental health worker has been vacant for over a year, the project has been understandably less successful.

Appendix D
Community Visits Notes

Community Visits

The comments, needs, and solutions documented in this Appendix are as expressed by the participants and do not necessarily reflect the views of the consultants, the project steering committee, the NADC or the Alberta government. Time did not permit independent corroboration of the problems and needs in each community, although there is no reason to suspect that the concerns expressed by service providers and residents are invalid.

Beaverlodge

Community History/Environment

- Beautiful country, sane pace, stable community, good basic services.
- Had a boom in late 1970s. Lost the small town atmosphere. More transients.
- Fairly stable population. Older families. Extended families.
- Some young professionals moving in with higher expectations regarding services.
- Some surrounding communities have more transients, more new families.
- More single parent and blended families cropping up now.
- Growing economic pressures with farms in trouble and more and more families with both parents working.

Community Strengths/Weaknesses

Strengths

- Small community. People know each other. Friendly, helpful.
- More awareness about mental health now. People talking about it. More are accessing services.
- Local support groups springing up out of community frustration with lack of services. Run by locals who have taken training.
- Schools and churches are actively involved. Good cooperation. No jurisdictional barriers in getting access to clients.
- Mandates not a problem. People do what they feel they have to.
- Good cooperation among RCMP, doctors, hospital and Social Services.

Weaknesses

- Lack of local services. People often have to travel.
- Not enough recreation and cultural activities.
- More and more hopeless for youth in this community.

Service Gaps/Weaknesses

- No local Social Services office.
- AADAC only visits two days per month.
- More private counsellors available, but quite expensive.
- Social Services has bad reputation. Bad rapport with schools. Slow to respond to child welfare investigations. High turnover. Seem disorganized.
- Counsellors overworked. Long waiting lists. Mental Health doesn't always come weekly as scheduled.
- Lack of effective suicide intervention service. Risk that some in crisis won't get appropriate intervention. Police sometimes reluctant to intervene, particularly with teens over 16, and parents can't order an assessment. RCMP don't get enough training in suicide prevention. Local hospital will admit people with overdoses, but won't admit those at risk of suicide.
- Have some volunteer-run groups. Hard to sustain without professional support. More effective with professional coordinators.
- Six month waiting list to get students assessed.
- Grande Prairie crisis line having trouble keeping enough volunteers to staff the telephone lines.

Service Impediments

- Some clients find it hard to travel to services (e.g., single parents), although many don't mind the travel and prefer to receive services outside the community.
- Many good pilot projects are terminated because funding is only temporary.
- Many agencies having to cope with cases they are not fully qualified to deal with because they can't refer these clients to an appropriate service that can take them in.

- Supply of professionals drying up. High demand in city keeps them tied up, even with vacancies and contract money available.
- Reduced staff productivity due to travel.

Professional Issues

- Government pay grid not competitive.
- Caseloads are similar to city, but less time to service because of travel. Higher stress and risk of burnout, even if they love the north.

Coordination Issues

- No formal interagency group or committee. Joint initiatives are *ad hoc*.
- Schools want more coordination. Hard for them to get information on students they refer to another agency. Maybe teachers aren't trusted, but they could possibly be more involved in conferencing with outside professionals.
- People seem reluctant to share information. Some assume it can't be shared. Mainly attitude and awareness problems. Unclear as to who should be responsible for the communication, the one who initiated the referral, or the one to whom the client was referred.
- Spectrum (Grande Prairie) should be benefiting the outlying communities. Nothing tangible has happened regarding coordination with local agencies.
- Poor coordination between agencies (as perceived by public).

Falher

Community History/Environment

- Higher turnover in family farms. Also new alfalfa plant is a large employer. More transients than 10 years ago. Brought a lot of problems with them.

Community Strengths/Weaknesses

Strengths

- Free lifestyle, little stress.
- Good municipal support for FCSS.
- Good family support systems. Extended family networks. Takes some pressure off formal services.
- Better awareness in community that help is available because of FCSS and AVC courses.
- Good volunteer base. Strong volunteer tradition.
- Good cooperation amongst surrounding communities to work together (e.g., recreation, FCSS).

Weaknesses

- Hard for newcomers to get connected (e.g., English-speaking). Easier to get connected if newcomer is outgoing and willing to get involved.
- Families help families more so than neighbors help neighbors.
- Area is in between major centres. Isolated a bit, partly by geography, partly by language.

Service Gaps/Weaknesses

- Not totally crisis-driven, but many agencies seeing more of this. Crises not being dealt with (e.g., teens). Some local service providers dealing with cases they would rather refer, but no one to send them to.
- Both Mental Health and Social Services (Child Welfare) have bad reputations.
- Need school counsellor. Person doing it isn't a teacher. More supportive listening. Not really counselling.
- Need more prevention/early intervention in the schools. Need "feelings teacher" as counsellor in elementary schools and more counsellors in high schools. Spread too thin. Lack of community/school liaison.
- Need youth support group (group counselling) outside of the school, for young adults (e.g., dropouts, recent grads). Mental Health worker could support the group as well as do counselling.
- Need to expand to 24-hour crisis line.
- Some crisis intervention capacity in the community, but limited. People feel inadequate. Hard to keep volunteers for crisis work. Medical services usually don't get involved unless the client is homicidal or suicidal. Mental Health only in one day a month. Can't do crisis intervention.
- Lack of crisis counselling. Have to be a serious suicide risk to get into Mental Health.
- Lack of early intervention services and post-crisis/treatment follow-up in the community.
- Need family counselling (multiple problems).

- Need crisis intervention, assessment and long-term therapy for families. Child Welfare intervention is insufficient.
- Need to be able to access contracted psychologists for other than Child Welfare cases.
- Some lack of services for seniors (e.g., retirement counselling, alcohol counselling, emotional support). Funding cutbacks are hurting special needs groups (e.g., seniors, mentally disabled).
- Need support group for adults from dysfunctional homes.

Service Impediments

- Families can be a roadblock for some who need professional services. Try to keep it quiet, keep it in the family. Usually another family member comes forward first. Key community resources can also open doors if they have trust and credibility.
- Use of paraprofessionals not necessarily a barrier except for serious problems requiring professional help (e.g., suicide, sexual abuse). People will come to local paraprofessionals if they have good training and are recognized/valued. Important that they act professionally regarding confidentiality.
- Difficult to cover the area from outside. Poor transportation system. Barrier to accessing services in other centres, or bringing services in.
- Services are scattered. Some in Grande Prairie, some in Peace River, some in High Prairie, some local. Hard for consumers to know. Often get bounced around between jurisdictions of provincial agencies.

Professional Issues

- Local service providers dealing with cases they would rather refer.
- Need salary incentive to recruit staff, even if they eventually leave. Better to have someone for two years than not at all. OK to train locals, but can't get them to fully qualified level. Still need professional support.
- Education is a real stumbling block. AVC has good programs, but funding being cut. Hard to get instructors. Universities will send green graduates, but not students. Reluctant to place students in rural practicums because of lack of supervision.
- Professional development is important for retention. OK to travel a bit to take courses. Can be a perk.
- Burnout is a bigger factor than career stagnation. Need more peer support for sole practitioners.
- Hard to meet expectations of city people re culture, recreation, entertainment. Many come with idea of staying only a few years. Career path isn't here. Some professionals leave when children reach high school because of a lack of services.

Coordination Issues

- Lack of follow-up by Child Welfare on sex abuse. Local service providers disengaged after referral, but want to stay involved/informed. Social Services doesn't seem to trust/value local resources.
- Hard to establish rapport with outside workers because of turnover. They don't consult.
- Interagency works well, but doesn't include all the key players, so hard to set up initiatives like case conferencing and joint programming. Could do more with interagency.

Solutions/Innovative Approaches

- Paraprofessionals based in community provide better follow-up with the client and family. Mental Health could recruit people right in the community (e.g., retired professionals).
- Establish better communication and more of a team approach between outside and local service providers. The treatment team should involve local resources.
- Coordinate more programs through interagency. Would allow more efficient use of shrinking resources.
- More rural practicums. Need funds to pay for housing and cost-of-living. Should be part of their course work. Also have to recognize and compensate regions for training overhead.
- Currently 17 single-person offices in Mental Health. Possibly better to recruit to regional service centres (e.g., Peace River). Easier to get people to come. Better collegial support.
- Challenge educational institutions to bring extension courses to the community rather than having people drive to a regional centre. Maybe

use teleconferencing/distance education technologies.

- Psychological services should be provided under provincial insurance plan. Maybe for special regions that have vacancies.
- Home Services could expand to provide formal mental health services. Nurses are often first to see problems. Could have psych nurses, social workers on staff. Other key access points are schools and general practitioners. Key on these as referral sources.
- Use mobile mental health clinic involving professionals and practicum students.

Fort McMurray

Community History/Environment

- Fairly young community.
- Large youth population.
- Large transient population in camps who have their own problems. This puts pressure on services.
- During boom period, a disproportionate influx of people came in with problems; now part of the fabric.

Community Strengths/Weaknesses

Strengths

- City residents are open, cooperative, tolerant.
- Strong sense of community.
- Fairly self-contained service area.
- Agencies are less "turf-oriented" now than in early 1980s; several joint-funded projects as agencies responded to government cutbacks and began looking for internal solutions.
- Excellent networking among service providers.

Weaknesses

- Lack of extended families.
- Company town anxiety. Community affected by rumors, oil prices, company layoffs, etc. Ripple effects.
- Lots of shift-work. Chosen by employees, but hard on family and community to work around odd schedules.
- Fairly widespread alcohol abuse. Not just with transients.
- Youth drug problem is a major concern.
- There are a lot of lonely people (adults and kids) among newcomers.

Service Gaps/Weaknesses

- Still highly reliant on outside professionals.
- High percentage of families with both parents working; lack of programs/activities for youth; shortage of child/day services.
- Need child mental health programs (e.g., day programs); can respond to one-on-one child/family counselling needs. Also need a residential program for difficult kids.
- Need community-based program for teens returning from residential treatment programs. Also need '12 Step' teen alcohol and drug self-help group: adult groups (AA, NA) inappropriate.
- Lack of counselling for sexual abuse victims and offenders. Also need program for batterers.
- Lack of appropriate services for the four native communities in the area. Also lack of follow-up on reserves.

Service Impediments

- Confidentiality problem because of small town environment; stigma associated with needing mental health services.
- Long waits to get appointments with psychologists.
- GPs not well informed re mental health problems.
- Reduced government funding (50% reduction in last few years); asking community do more with less; agencies on 'shoe-string' budgets.
- Volunteer resources are currently being overused.

Professional Issues

- Turnover is a big problem. Clients are not impacted directly because of larger base of staff here, so this doesn't create a hole in operations.
- Too high a proportion of inexperienced professionals.
- No recognition (extra funding/manpower) for role played in training new professionals coming for experience.
- Have vacancies that can't be filled; need recruitment and retention packages.

- Hard to attract qualified staff without incentives; hard to retain staff without higher pay due to cost-of-living (17% higher than in Edmonton/Calgary). Companies adjust for it and school board grids reflect it, but the provincial government does not.
- Small agencies (one to two professionals), in particular, cannot offer competitive benefit packages.
- Many young professionals leave to pursue jobs in Edmonton/Calgary as the career path is considerably better there.
- Pay may be less a cause of turnover than lack of development opportunities and feelings of isolation. Many would still take a southern appointment despite incentives.
- Need Master's level extension programs here. Little interest from Alberta universities. More from other Canadian and American universities. Extension for upgrading of nurses to BScN was very effective.
- Hard to accept lower qualifications (i.e., paraprofessionals) in place of professionals. Community here expects qualified service providers.
- Agencies use paraprofessionals. Have a good supply of "near qualified" people who don't upgrade because they would have to travel (Edmonton, out of province) to get training. Province not prepared to assist in their upgrading.
- Need local training program for people to become involved in helping professions. Get a lot of applications from local people, but they lack credentials and the means of obtaining credentials locally.
- Have local labor pool (e.g., spouses of oilfield workers) that could be tapped into. People often leave because spouses are unhappy.
- Unions and bargaining bodies are based in Edmonton. Not effective in bargaining on behalf of northern workers.

Coordination Issues

- Have a Psych. Service Board. No regular interagency committee. *Ad hoc* meetings. Working on joint case presentation/consultation for sharing information and awareness between service providers. A few agencies are trying to implement regular meetings between service providers to review special cases.
- Some lack of coordination in services as perceived by school system, but starting to pull together better now.
- Pockets of integration and coordination have sprung up spontaneously between agencies with similar clientele/mandates (e.g., Venture program). No "master plan" *per se*.
- Fewer coordination/cooperation initiatives between major "professional" agencies and other community-based "paraprofessional" agencies, but getting better.
- Last two years have been very positive re mental health service coordination (Venture program a strong positive cause/effect).

Solutions/Innovative Approaches

- Compensate rural/remote regions for training overhead borne for the benefit of the big cities.
- Professional consultation through distance education techniques would help reduce feelings of isolation.
- Encourage training programs to provide practicum placements in Fort McMurray: excellent experience. Also would tap into larger base of prospective employees who might, if exposed, consider "northern practice".
- Increase bursaries for locals to get training.
- Recruit more from U.K. These people come to Canada to live and work and are less likely to move. Also they tend to get involved in community.
- Provide long-service increments as incentive to stay in the north.
- Use Code 1 dollars (salaries) saved through unfilled vacancies to contract professional services (e.g., psychologists), and for spending on other human resource activities: recruitment, training, bursaries, etc. Don't allow these funds to be absorbed by Treasury.
- FCSS saw gaps in early intervention. Responded with individual/family and school counselling programs with emphasis on family counselling.
- Institute a student assistance program modeled after employment assistance programs.
- Teens returning from residential drug treatment programs are an asset to the community that is not being utilized.

- AHCIP should fund long-term residential treatment programs (out of province; States) that are not hospital based.
- AADAC has recently committed two blocks of time/week for adolescent intake and assessment, and it provides referrals for inpatient treatment to AADAC's new adolescent day treatment program in Calgary and Edmonton. Also, an adolescent group ("Making Choices") meets regularly.

Grande Cache

Community History/Environment

- Town is barely 20 years old, and has a relatively young population.
- Heterogeneous cultural/value mix, with many residents from other provinces and countries.
- Massive mine layoffs in '82. Frequent boom and bust cycles. Town has endured many crises that have served to bring people together — "survivors". Strong sense of community.
- Many changes in last 5 - 10 years. Correctional Centre is a major new employer. More stable/affluent now with less transiency, but still significant financial pressures (e.g., single parents, young families) and related personal and family problems.
- Natives on co-ops are much older, very isolated. Inadequate housing and transportation exists, along with high alcohol abuse and suicide. Some co-ops moving to take more local control — going dry, opening elementary schools.

Community Strengths/Weaknesses

Strengths

- Mountain setting, fresh air, friendly people, small, slow pace, safe, good place to raise a family.
- 'Best of both worlds' — close to city but still relatively isolated.
- Less transience with second generation residents growing. Strong sense of community, self-reliance, and proactive spirit.
- Good support from town for FCSS.

Weaknesses

- Limited employment opportunities for youth. Many stay but have nothing to do, get into trouble. Hard to get them into programs.
- Some loss of neighborly helping spirit compared to earlier times.
- A lot of shift work. Shift work makes it hard for some to attend organized functions. Also, the work is boring and tedious, leading to stress and disruptions to family life. No extended family networks for some. Not a lot for women to do. On own a lot and trapped in tedium of child care/housework.
- High cost-of-living. Hard on single parents. Stressful for young families.
- High dependence on mine. People feel vulnerable and anxious with every rumor. Mine could be better corporate citizen re employing local youth and helping to fund services (prevention, treatment).

Service Gaps/Weaknesses

- Need full-time psychologist to do testing and individual counselling.
- Negative image of Social Services in community.
- Crisis line is not dependable. Poor follow-up. Need 24-hour crisis line specifically for the public.
- Need youth training programs, youth group/day home, better promotion of services for teens.
- Need alcohol counselling, offenders/batterers programs, counselling for victims of sexual abuse, family counselling, suicide prevention/crisis intervention services.
- Need transportation to/from native co-ops so people can access recreation and entertainment. Need home for native seniors using native homemakers and supervisors. Need a place in town where kids could drop in and wait for parents.
- AADAC worker is based in Hinton and only comes out every two weeks. Need full-time AADAC counsellor. No NNADAP services available.
- No private psychologists. Psychiatrist with Correctional Centre not available to community.

Service Impediments

- Rigid centralized services are not effective in a remote area. Too highly structured.
- Reluctance of people to access services due to associated stigma. Confidentiality a major issue with service consumers and providers alike; concern that everyone in town will know of their problem.
- Out-of-town referrals too costly for some clients.
- Lack of funding continuity. Difficult for local agencies to continually grind out funding proposals.
- Too much overhead in small towns with independent government agencies.
- Many funding inequities. Only FCSS has per capita formula. Statistics used by province don't reflect relative needs in communities.
- Difficult to service native co-ops because they are very isolated and lack on-site coordination.
- Local resource people are not being utilized. Not valued by existing agencies who could refer clients (e.g., native healers, etc.). Need mechanism for such people to prove themselves and become integrated into the service network. Too much reliance on outsiders. Inefficient use of funding because of high rates/salaries and travel costs for outside "professionals" who have to travel to the community.
- Some established service providers don't recognize spiritual dimension to some problems; don't think of the clergy and native healers as a potential resource.
- School system favors teachers for preventive mental health programs in schools. Hard for service providers to get access to this important target group.
- FCSS mandate is preventive, but is restricted from doing preventive family counselling. This service falls through the cracks.

Professional Issues

- Local provincial agencies have been able to identify well with the community without being hindered by their parent organizations. Minimal problems with mandate restrictions for new initiatives.
- Mental Health worker is locally based. Large caseload but sees relatively few crises: does not feel at all restricted by department mandate.
- Good supply of volunteers and paraprofessionals who could work in human services with appropriate support/training.

Coordination Issues

- Strong interagency group: more than just information sharing. Has also initiated joint action to fill gaps.
- Some overlap between agencies — could be tightened up. Little interest in establishing a centralized intake/assessment/referral system. Some concern over confidentiality.

Solutions/Innovative Approaches

- Important to support communities to develop their own resources. Need for more paraprofessional and volunteer involvement. Use professionals for consultation, backup, inservice, case conferences, collegial support. Mental Health could get more mileage out of existing resources if community-based paraprofessionals were used.
- Have to create a career path for paraprofessionals in the community. Need to "decentralize and deregulate". Let communities determine acceptable standards for their care providers.
- Recognize and pay native elders as service providers.
- Get AGT to set up regional crisis line as a good corporate citizen.
- More privatization - greater allocation of current funding to contract services provided by private practitioners within the community. Create mechanisms by which community-based service providers (formal and informal) can be evaluated and included in the network.
- Train professionals to consider spiritual factors during assessment and more actively refer/consult with clergy. This is important for the RCMP as well as for professional counsellors.
- Adopt a community school concept, where there is greater partnership in the classroom among teachers and other service providers regarding programs for children, including mental health promotion, peer support, etc.
- Define "basic mental health services" that all are entitled to.

- Money from the government's new family initiative should be allocated through FCSS for family counselling and other family related programs rather than creating a separate infrastructure.
- More promotion is needed to change attitudes about people with mental health problems — that it's OK to come for help, and OK to help your neighbor. Need to reduce stigma.
- Promote volunteerism. A good mental health strategy for the volunteer personally as well as beneficial to the community.
- Professionals working out of a multipurpose facility could be more efficient by cost-sharing of overheads (space, reception, secretaries, etc.), and by coordinating services better. Don't necessarily need to pool funds under a single board.

Grand Centre

Community History/Environment

- Tri-community area (Grand Centre; Cold Lake; Medley; including Cold Lake First Nation Reserve) with several distinct communities: Military Base (3-year posting), Esso workers (2-3-year term), local farming and business community, natives (on and off reserve).
- Community affected by frequent boom and bust cycles (oil and military, somewhat).
- High transient population, including professionals and laborers.
- No major resurgence of traditional native healing approaches.
- Very young community. Few seniors except on reserve.

Community Strengths/Weaknesses

Strengths

- Good community spirit.
- Much expertise available to the community with educated professional population who are highly committed/involved while here.
- Spouses of transferred employees are good source of expertise — new people bring new ideas.
- Psychiatrist on military base available to the community on limited basis. Esso has good EAP for employees. Cold Lake Reserve has own Health Centre; active NNADAP program.

Weaknesses

- Difficult to maintain continuity in community activities with high turnover in population.
- Impending cutback of services for dependants of military personnel will put strain on community resources.
- Many residents lack extended family and long-term support networks.
- Jobs left for locals are less satisfying than those for 'imported' workers.

Service Gaps/Weaknesses

- Need for recognition and early treatment of mental health problems and rehabilitation programs for those with chronic problems.
- Agency policy and flexibility vary with incumbents.
- Crises backing up into the caseloads of many community agencies because of inadequate mental health treatment services available. No time for promotion and prevention work.
- Lack of children's services: testing, assessment and treatment. Mental Health child therapist position vacant. Bonnyville child psychologist for Social Services clients only. School liaison workers overworked and no one to refer to for treatment. There is no one in community with expertise in child mental health needs/problems.
- Lack of forensic services. High probation caseloads. No local services for court-ordered treatment. No treatment for offenders (family violence, sexual abuse).
- Natives on reserve have to travel to Bonnyville or Grand Centre for treatment. Treatment by psychologist on-reserve requires cumbersome referral through GPs.
- No outreach by agencies because no capacity to handle new cases and no one to refer to for treatment.
- Three-week limit in women's shelter is inadequate. Many residents need life skills training. Social Services restricts funding for apartments (once per year) so many residents forced to cycle through the shelter four or five times. Shelter is understaffed: one person on night shift has to handle operations, security, crisis

line. Crisis line is getting mental health calls by default. No counselling for victims or offenders.

- Need crisis intervention program.
- Unable to recruit and retain mental health therapist. Currently one position filled but two vacancies. Local psychiatrist recommends four minimum.
- Although need for mental health services is greatest, there are also needs for more support programs, including family counselling.
- Need psychiatric nurse to deal with psych patients who end up in local hospital.
- 20-year resident has seen services being continually eroded; phoned Mental Health office for answers, but only got recorded message: 'This is unacceptable.'

Service Impediments

- Low priority within health system for mental health. New hospital has space and medical staff, but no mental health workers.
- Transportation to outside services costly for many in community not employed with Esso or military. Costly to bring in contract specialists.
- AADAC staff cut in half last year; now three weeks waiting period for appointment.
- Women from military base reluctant to use shelter because it may reflect on husband's career.
- Workers having significant downtime and loss in service capacity because of travel.
- Local hospital not designated for psychiatric care.

Professional Issues

- Many want local training to deal with cases. Staff who want to upgrade must leave community to get training in the city.
- Mental Health not recruiting aggressively enough.
- Professionals recruited from the south have unrealistic expectations of the community and the job. They are easily disillusioned. Lack of social outlets for single workers. Lack of collegial support causes early burnout. Lack of supervision in setting limits and realistic expectations for themselves and their role in the community.
- Provincial grid for Mental Health workers doesn't account for higher cost-of-living in north, or for enhanced job content/demand over comparable position in city, which has less responsibility, stress, risk, support and clinic management responsibilities.

Coordination Issues

- Coordination of services and agencies could be improved. Many community members in need of services are unsure where to turn or whom to call.
- Tri-Town Interagency group can only go so far; need regional coordination committee (Bonnyville; Cold Lake; Medley; Grand Centre).

Solutions/Innovative Approaches

- Institutions should offer students field placements in northern communities. Better chance of attracting new staff if students have a better understanding of northern practice.
- Nursing/hospital resources are not being exploited to dealing with community mental health issues.
- Define a shared FCSS/Mental Health position.
- Greater local autonomy and accountability for Mental Health and Social Service programs.
- Provide group therapy program for mental health clients. Also, facilitate the development of more self-help groups.

High Level

Community History/Environment

- 17 distinct communities including bands and settlements. Large service catchment area covering about 16,000 people within a 250 km radius.
- Fort Vermilion is an old farming community with strong family networks. There are few employment opportunities for youth, causing some to leave the area.
- High Level is a newer and younger community with a high proportion of transients. It has experienced periodic boom and bust cycles, but it is more stable now. People are beginning to see it as home with second generation families starting to establish themselves.
- La Crete is a Mennonite community established

in the 1930s. Pressures on families are being experienced due to a breakdown in traditional ways. Youth are taking jobs outside farming because it is too expensive to clear new land. Farmers have to take second job to keep their farms, leaving little time for family and community involvement.

- Good jobs don't go to locals. This disrupts communities.
- There has been substantial growth in social problems with economic development.

Community Strengths/Weaknesses

Strengths

- Wilderness and privacy provide strength for many who have chosen to live here.
- Most of major service agencies are represented in the community.
- High Level is a friendly community, and newcomers are still welcomed. The community spirit is improving now that people are tending to stay longer. There is a large pool of local talent that could be groomed as paraprofessionals.
- Rainbow Lake is an active, dynamic community with strong local leadership.
- La Crete women are a strong source of family and community strength, and a strong helping tradition is present here.

Weaknesses

- Isolation, especially for spouses who have been transferred here. Local cliques are often hard to break into, on the one hand, and people are reluctant to make friends because of high turnover rates — they've been hurt too often in the past when close friends have moved away.
- Family fragmentation is a growing problem.
- Some erosion of community self-help spirit due to reliance on outside professionals that turn over regularly. Also, long hours of dissatisfying work experienced by some reduces the time and energy that is available for family, recreation, socialization and neighborly helping. The community often feels itself as being in a "survival mode". Volunteer energy is reduced as a consequence.
- Lack of alternative recreation/entertainment activities.

Service Gaps/Weaknesses

- The "person" is the "service" here; thus, service is inconsistent due to high turnover rates in professional care givers.
- Lack of prevention/promotion services, adolescent services, family counselling, early intervention, post-treatment follow-up, speech therapy, local testing and assessment, local psychological and psychiatric treatment services, school counselling and family liaison (e.g., elementary level).
- Need psychiatric beds. RCMP cells must be used to provide secure accommodations for some psychiatric patients waiting to be transferred to a southern treatment centre.
- Need retreat for men, transitional homes, respite for families, crisis and information referral line, offender treatment services, "singles" programs.
- Lack of residential facilities for handicapped.
- Need home visits to get over stigma barriers around accessing mental health services.

Service Impediments

- Long distances to travel to get to some services.
- High turnover of staff which impedes the development of trust. Some perceive outsider service providers as "interfering" with community values.
- Large number of different types of communities to serve, each with differing needs.
- Some agencies have restrictions imposed by funding bodies which serve to control service access. Current system is agency-oriented rather than client-oriented. Too many eligibility restrictions. These are causing some potential client groups to be missed.
- No one to advocate for clients who aren't served and don't advocate for themselves. Many residents don't know what services are available or what their rights to service access are. Local citizens aren't well organized to act for themselves. Need support person, or catalyst, to get self-help groups and activities going.
- Funding formulae don't adequately account for local conditions. Driving takes 20% of a service provider's work day. Weather is also a factor.
- Some programs bring in high-priced help when locals would be just as effective, if not more so. There is an attitude that locals not competent.

- Service providers are often too busy to pursue interagency initiatives or address service gaps.
- Service providers (particularly newcomers) don't always know what the other agencies do.
- Medical staff are not as aware of community resources as they should be; nor are they well trained in mental illness. Medication is stressed rather than referring clients to other services providers in the community.
- Stigma around mental health issues is a barrier to some.
- School/family liaison people are regarded as "truant officers".
- Social Services Income Support staff have tended to make people with mental health problems jump through hoops that can exacerbate their condition.

Professional Issues

- Hard for newcomers to fit in. No formal community initiative to welcome, orient and integrate newcomers other than Welcome Wagon.
- Newcomers (helping professionals) are not oriented before coming to the north, resulting in "culture shock". Often these people are filling a vacancy so there is no opportunity to phase into the job with the incumbent's help.
- Many pay inequities exist: school counsellors paid as teachers, so no incentive for them to get extra training; salaries don't factor in higher cost-of-living.
- Staff have to bend rules imposed by departmental mandates in order to serve community needs. This can be frustrating.
- Provincial civil servants have no one to advocate for them re employment/pay issues.

Coordination Issues

- Interagency group is good for sharing information, but it is not a formal service coordination mechanism. People are too busy to get new coordinated initiatives going.
- Some service providers are concerned about client confidentiality with information sharing, case conferencing or centralized case management approaches.

Solutions/Innovative Approaches

- Improve orientation for professionals including cross-cultural training.
- Develop more home-grown programs using local paraprofessionals with training and support from provincial programs. Professionals from "outside" should act more as support for locals. Cultivate local talent through inservice programs, as they tend to see their long-term career in the community.
- Enhance retention through more training and networking opportunities with peers from other areas so that workers won't feel so isolated.
- Provide information on the region to prospective employees so they can better screen themselves. Possibly use videos, trade fairs and media advertising to promote the region as a place to live and work.
- Integrate "rural practice" content directly into standard curricula for all professionals, not just optional courses.
- Provide bursaries and scholarships for local people to go outside for training/upgrading.
- Implement an accelerated pay grid that provides better incentive for people to stay longer.
- Implement a central access (intake, assessment, referral) point for clients. Possibly through the hospital because it has the least stigma attached to it. Central intake would allow for better caseload statistics, and would catch those not able to be served who fall through the cracks in current statistics. Also there should be more efficient use of resources because of less duplication in administrative overheads.
- Recognize interagency time as "service time" and allow for it in budgeting. Same with in-service.
- Use distance technologies for inservice training.
- Education North pilot project was demonstrated to be effective model for northern training with local design and control. Unfortunately killed by bureaucrats.
- Use a travelling clinic of specialists who come through regularly to provide service, do case consultations and provide inservice training.
- Schools are the long-term key. They are a source of values and an important access point for children and families.

- More emphasis on community development — help the community organize to help itself.
- Northwest Health & Social Services Board is a good concept, but it is breaking down. Too hard to coordinate regional priorities between agencies with provincial mandates and "earmarked" funding. It might have worked better in a single community or more homogeneous area.

Lac La Biche

Community History/Environment

- Community is a mosaic of many cultures (Ukrainian, Lebanese, French, White Russian, two Metis colonies, Cree and Chipewyan native communities).
- Government is the primary industry followed by agriculture and tourism. Significant split between rich and poor. High unemployment rates.
- High transient population, particularly AVC students.
- AVC is a community unto itself. Four hundred students/families in residence (many native). Image problems in the community and high incidence of suicide attempts, family violence, drug/alcohol abuse.
- Some resurgence of native healing traditions on reserves. Not in town.

Community Strengths/Weaknesses

Strengths

- Strong, active public school system.
- Multiculturalism.
- AVC provides a good, alternate, economic base for the town.

Weaknesses

- Friction between new and old residents, between established businesses and new development.
- Lack of integration between native and white communities and between different native communities.
- Fragmented community leadership; lack of appreciation for human services; not friendly environment for those willing to take leadership role in human services area.

Service Gaps/Weaknesses

- Native communities are experiencing greatest problems from lack of appropriate mental health services.
- Need family violence program, also treatment and self-help groups for batterers.
- No community-based post-crisis and post-residential treatment programs.
- Lack of resources in public school system (e.g., facilities and staffing in guidance, counselling and special education).
- Lack of mental health services is major gap. Two vacant Mental Health therapist positions, with no mental health worker for over a year. Local agencies have nowhere to refer to, creating a backlog and interfering with their other responsibilities.
- Local agencies are crisis-oriented due to lack of available mental health services.
- No local treatment is available for family violence victims and offenders.
- Visiting psychiatrist retired and has not been replaced.
- AVC lacks professional consultation and support and can't provide longer term treatment services. Some AVC students have to quit school to get treatment in the city and risk losing other school support services.

Service Impediments

- Some agencies have lost momentum, rapport/visibility and local cultural sensitivity through past upheavals.
- Not enough choice for people. Some prefer service from a local paraprofessional. Some want anonymous service from professional in Edmonton.
- Some residents do not trust local service providers: confidentiality issue.
- Existing services understaffed, especially Mental Health. Income Support caseload up 75% in two years. Child Welfare caseload on the rise. Police cutbacks have also occurred.
- Recent move by Mental Health to hire lay mental health worker with community development role is good idea but won't work without clinical backup/support — will not reduce demand, but may increase it.

- Joint AADAC/school program and CARE program lacking referral to treatment resources for serious cases — few exist.

Professional Issues

- High turnover in Mental Health caused by unclear/changing job description, overwork, stress, job constraints, poor pay and lack of collegial support.
- Local AVC graduates have to leave community for further education. No field placements in the community for students beyond AVC level.
- AVC has "richer" services than that available to town residents. Large counselling team with good collegial support and general working conditions. Not interested in vacant Mental Health positions.
- Mental Health not perceived as actively recruiting. Community supports reclassifying one position to Community Development, but only if person is backed up by filling vacant therapist position.
- Outsiders hired for local positions have been trained in urban approaches and have unrealistic expectations of practise in community.
- Recruitment issue less related to town than the job itself. Have at least three MAs in psychology in town, but none want the job.

Coordination Issues

- Interagency meets every two months. Useful for sharing information, but no time for development of innovative projects. Some joint programs. Some agencies looking for more leadership from FCSS.
- Need for local umbrella group to coordinate treatment. FCSS or interagency committee could play a stronger role.
- No major problems with jurisdictional overlaps or constraints. Some problems for natives with federal restrictions.

Solutions/Innovative Approaches

- Need new image for mental health team. Too long associated with chronic care.
- Major joint program with schools, AADAC, FCSS, native participation: building self-esteem.

Swan Hills

Community History/Environment

- Town only 30 years old. Population relatively young.
- Used to have a lot of transience. More stable now. More long-term families, more mixing in neighborhoods.
- A different town after 7 p.m. Taken over by younger transient male population socializing in the bars.

Community Strengths/Weaknesses

Strengths

- Small, slower pace, good recreation, beautiful scenery, friendly and helpful people.
- Good community spirit. Concerned.
- Fairly active recruitment of newcomers to get involved in the community. Companies encourage employees to participate. Helps with their adjustment. Good for town. Strong volunteer component.
- Strong FCSS program.

Weaknesses

- Lack of established family networks/extended families. People with difficulties have to leave the community because can't stay with or get support from another family member.
- Some cliques in the community. Not as bad as it used to be. Still takes time for newcomers to fit in, particularly if they don't try to get involved. Young mothers are most isolated.
- 50% of work force is shift-oriented. Men preoccupied with work. Women on own a lot. Hard on families.
- Hard to be single in this community. Not much to do.
- No local high school. Teens have to travel to Barrhead. Tiring. Saps energy. Friends and extracurricular activities tend to be in Barrhead. Feel isolated here.
- Many parents move out when teens reach high school because they don't want children bused to Barrhead.
- Town has undeserved image problem with the big companies. People come in with a negative attitude. Takes longer for them to get plugged in.

- Pretty lonely place in the winter and during holiday periods. People leave town. Pretty deserted.
- Service industry can't offer same salary and benefits as oil companies. Don't have access to same company supplied services. More in need of government services.
- Lack of alternative youth activities outside of hockey and organized sports.

Service Gaps/Weaknesses

- Community feels short-changed by inequitable allocation of resources. Smaller centres just don't get fair share and have to find ways to compensate.
- All services see crises backing up into their areas. Causing problems in doing preventive work because of the time and stress associated. Want to set up peer support groups. No time.
- No day care or child care services for young mothers.
- Limited women's programs. Have to be a joiner or easy to be left out. Welcome Wagon is a one-shot service. Not keeping up with the backlog. Doesn't have a comprehensive list of names.
- RCMP apprehends people who could have been helped much earlier. Catch 22. They can't get into service until they reach a crisis point because of long waiting lists.
- Lack of community-based follow-up for post-treatment. Need support groups.
- FCSS provides counselling out of necessity.
- Need a safe house in the community. Multipurpose for kids, women, family respite.
- Need a crisis team.
- Need more family recreation opportunities.
- Growing teen problems with drugs and alcohol. Difficult to penetrate. Need peer groups. Need to get into the schools.
- Teachers also quite transient and hard to get involved in extracurricular/volunteer activities, including mental health.
- Need to start mental health education and services in elementary school.
- Need teen drop in centre.
- Need to support groups for mothers with young children, single parents, teens.
- Need more public education so people recognize symptoms in themselves and others. Need more publicity of services available so people know where to go.
- Need more space to hold meetings.

Service Impediments

- Have to have statistics to justify full-time staff based in the community, but hard to get the statistics.
- Many not aware they need help. Many not aware what services are available.

Professional Issues

- Culture shock for professionals coming here from bigger centres. Helps if they get involved in the community.
- Mental health very stressful work. Easy to burn out. No one to talk to. Many providers are based outside the community and have to travel. Travelling really hard on people.
- Lack of collegial support. Need more support for service providers. Working on care for the caregivers.
- Have to "bend" mandates in order to meet community needs. Can be hard. Can get "hands slapped".
- Need to have premium pay grid to attract and retain staff.
- Workers don't have to have Master's degree to be useful in the community.
- Paraprofessionals would be acceptable to the community. Better than having no one. Rather have someone come in than have to drive to Barrhead.
- Hard to get practicum placements. Universities feel there isn't enough supervision or enough caseload variety.

Coordination Issues

- Community perceives a lack of communication and coordination between various health services.
- Mandates and jurisdiction complicate local coordination and cooperation. Problem particularly with Social Services.
- Current interagency group working well. Less territorial than before. Companies not currently represented. Have done some joint funded projects (e.g., Nobody's Perfect, day care

proposal). Mostly information sharing and coordination of planning.

- Have talked about central intake and case management. Would improve service coordination between care givers. Confidentiality should not be a concern once trust has been established.

Solutions/Innovative Approaches

- Active recruitment of newcomers into service activities.
- Job-sharing would be practical approach. Get two people to fill a full-time Mental Health position. Would make the position more attractive because staff would have a colleague for support, and would also have a diversion from the stress through their other half-time role.
- Use local hospital as a safe house. Lots of unused space. Less stigma for people to go to the hospital.
- Hospital could serve a stronger role in community health, including mental health. Could be used as a treatment centre for alcohol. Could be used to hold support groups and other meetings. Would provide better collegial support for staff and better potential coordination of services. Possibly joint funding from Social Services, Mental Health and FCSS. Mobile team could use hospital as a base when visiting the community.
- Community would be more successful filling Mental Health vacancies if money were channelled through FCSS. Funds could be put into local priorities (e.g., family/school liaison worker). Don't have to have Master's degree.
- Use more paraprofessionals for pre- and post-crisis work. Psych nurse in hospital could do some counselling.
- Use Mental Health and Social Services contract money to bring professionals into the community, at least as backup support (i.e., consultation) for local service providers.
- Education system needs to promote mental health to reduce the stigma so people won't be afraid to access service or won't feel they have to leave town to get help. Need to improve the image of mental health. Maybe should find another word to replace "mental".
- Municipality and local employers might be encouraged to kick in funds toward a social worker to help with groups, do direct counselling, etc. Employers could offer services to non-employees.
- Mental health promotion needs to be more direct: "Do you have these symptoms? You're not alone. It's OK. Go get help. Go see . . ."

Wabasca-Desmarais

Community History/Environment

- Loss of native traditions and way of life.
- Change in traditional value system through education.
- Confusion in individual identity.
- Lack of meaningful/constructive local opportunities for employment, even with education.
- Loss of self-esteem — guilt, fear, anger, silence, numbness.

Community Strengths/Weaknesses

Strengths

- Freedom, space, clean environment, tradition of sharing.
- Resurgence in native culture/pride, and increasing desire for local control over matters affecting community, increasing rejection of dependence on state.
- Cohesive/cooperative interagency group (good basis for coordination of policy, planning, delivery).

Weaknesses

- Community politics, lack of openness/trust among community members.
- Fewer community gatherings, less community spirit and neighborly concern (except in times of crisis).

Service Gaps/Weaknesses

- Lack of community-based self-help/support groups to take over after professional treatment (in/out of community).
- Have to send offenders and victims out of community for treatment.
- Lack of public awareness of problems, causes, services available.
- Lack of services for men (e.g., AA).

- Need a "school liaison" (family counselling) person to work with families where children are having school problems because of problems at home.
- Need a teen drop in centre. Kids bored and need an alternative activity to drugs/alcohol. Not enough programs for youth — recreation, youth groups.
- Need parenting skills — kids run their parents.
- Need more family counselling to prevent suicides.
- Need outreach service. Doors will open once word gets around. Lots of problems to address that are hidden.
- Lack of major educational and other training institutions in the north — youth have to leave community/area to get further education/ employment. This tends to mitigate against community commitment to education.

Service Impediments

- Shortage of knowledge of how to channel emerging independent community spirit into action.
- Inappropriate statistics and measures — outsiders' definition of service need/demand doesn't recognize local value system. Local agencies lose funding because they're perceived by funders as not doing a good job or failing to meet government standards.
- Insufficient funding and funding continuity.
- Lack of accountability of outside service providers to the community.
- Excessive bureaucracy/too many "middlemen" — inefficient.
- Lack of appropriate facilities for certain activities (e.g., group work).

Professional Issues

- Professional bind for outsiders because local needs sometimes conflict with approved policies/guidelines/criteria established outside (e.g., eligibility for service).
- It is difficult for outsiders to win trust of people. This takes time.
- Sometimes difficult for local service providers to gain trust — service providers are not always perceived as professional or confidential. Normally not an issue, even with sensitive problems. Qualifications not a problem if there is professional backup (e.g., Slave Lake Mental Health Clinic).
- Staff turnover is not usually because of a salary problem. Outsiders frequently isolate themselves. Those that stay make an effort to meet people and make friends.
- More local people could be used to provide services (e.g., school counsellors, teachers). Many local people want/need certification, but no formal programs for training and career development. They have to rely on their own initiative. This is scary for most because they would have to leave town for long periods to get required training, and there may not be service jobs for them when they return. More community-based training opportunities are needed.
- There is a need for more awareness in community of the value of mental health services. There is also a need to increase the profile of mental health services to encourage their use and to encourage local people to get into the helping field.

Coordination Issues

- Lack of coordination at funding levels (not at delivery level) particularly re treaty vs. non-treaty, on- vs. off-reserve, north vs. south of Motherwell-Hunter line.

Solutions/Innovative Approaches

- Let communities determine objectives, methods and standards.
- Provide support for local groups — don't undermine them.
- Give more local control over funding and how it's spent. Pool funds from all sources and allow control by a local agency/board accountable directly to the community. Hire delivery staff, contract outside services, fund community service groups (including traditional helpers/ healers — medicine men, etc.), define own standards. Provide long-term funding commitments.
- A multipurpose community treatment facility is needed with space for treatment, group counselling, inpatient detox, outpatient services, counselling, etc.

- Community should make effort to help newcomers get settled. Show them around.
- Outsiders should be prepared to make a minimum commitment of three to five years in the community.
- Children are an important target group. Families can be accessed through their children. Otherwise, service providers wouldn't necessarily be able to reach these people.

Whitecourt

Community History/Environment

- Young, active, career-oriented. Seniors moving away. Many transients.
- Good employment opportunities, but disparity between rich and poor (unemployed).
- Boom in 1970s due to oil activity. Stabilized in early 1980s. Boomed again in mid-1980s with pulp/paper mills.
- Increasing number of transients with settling-in problems. Often the jobs they get are not what they had expected. Some bad apples coming in, and some with alcohol/crime problems.
- High-school graduates have lots of competition for jobs, many of which are filled by outsiders.
- Strong peer pressure at school.
- Social problem growth is faster than population growth. This is magnified because incoming families are under strain — high stress levels in the community.
- There is, however, a greater awareness of issues, and less covering up of problems now.
- Deinstitutionalizing handicapped along with aging has put more people in need of locally based services.

Community Strengths/Weaknesses

Strengths

- Natural setting but close to Edmonton.
- Friendly, easy-to-meet people.
- Recent growth in number, variety and maturity of human services. Good interagency group.
- Better education programming now.
- No loss in values among the youth. No inordinate clash between generations.

Weaknesses

- Not much for unemployed to fall back on in town. Lack of extended families for many. Thus, people have to rely on professionals, adding to caseloads.
- Many young people have to leave to further their education/career. This is hard on families. The community needs a post-secondary education facility.
- Young families are busy, many with both parents working. Many single people go to Edmonton on weekends. Lack of volunteer capacity in the community.

Service Gaps/Weaknesses

- Lack of staffing, particularly in Mental Health, AADAC, Legal Aid, causing long waiting lists. Intervention available at crisis stage only. Sometimes crises are handled by someone who can "make do" because qualified staff are unavailable. (AADAC will open an office in Whitecourt in April 1990.)
- Need a school/family liaison/counsellor. School counsellor sees family problems but has no time to follow up.
- Native counselling. There is nothing available that natives are comfortable with.
- Family counselling. Need more psychologists (or trained lay counsellors?).
- Need a men's hostel.
- Need more preventive educational programs (e.g., parenting, alcohol, mental health, assertiveness, self-esteem, etc.).
- Need local transition facilities and services for people going to or coming from out-of-town treatment/residential programs.
- Perception that AADAC clients are not satisfied with available residential treatment services, or with the utilization of local AA and NA self-help groups.
- Need group homes for mentally handicapped. Need start-up money to build these.
- Need a vocational/technical school to prepare youth for local jobs. It would also be good for the handicapped, learning disabled and high school dropouts to give them better career opportunities.

Service Impediments

- Service supply is generally not keeping up with demand. Most interventions are at the crisis stage.
- There is a lack of volunteers, and there is a high volunteer burnout rate.
- Many citizens don't know services are available in the community.
- Space is available in the new hospital design for the integration of mental health counselling services, but functional plan was rejected by policy makers, despite their supposed commitment to integration of services.
- Whitecourt Public Health has its own office and staff, managed out of Stony Plain. Doesn't want to integrate with the hospital, though this is desired by many at local level.
- Used to have a community school — good concept, but the program was cancelled.
- Difficulties in dealing with provincial policies that make it hard to customize services to meet local needs. Some service providers would like to be able to get more involved with local initiatives.
- Mills and oil companies not doing their share to address problems they are helping to cause. They don't participate in interagency discussions. There is also a lack of interaction between agencies, government and business.
- Human services not given high enough priority. They are always the first to get cutbacks.
- Many outsiders who come here to work don't make an effort to get involved in the community. Many never intended to stay — just getting experience ("Looks good on resume").

Professional Issues

- Non-professional lay counsellors don't feel competent to handle some of the cases they see because of the unavailability of professional staff to provide backup support. Staff could use more training (although they may not have the time to take on more cases even if they were trained).
- Local agencies often have money/positions, but can't find staff. Need financial incentives (not all agreed this would necessarily help with staff retention problems).
- Great disparities in pay for same positions in different communities. Not fair.
- Lack of career opportunities in the community for helping professionals. Many have to leave for career advancement.

Coordination Issues

- There are some coordination problems between agencies that may cause clients to be bounced around sometimes. Generally service delivery staff know who's in town and where to refer clients.
- Some clients with combined alcohol and mental health problems may fall through the cracks between AADAC and Mental Health.

Solutions/Innovative Approaches

- Post-secondary vocational/technical facility.
- "Clinic" model for service delivery. One-stop shopping or single point of entry would be more efficient so the clients don't bounce around or use multiple services.
- Pool funding resources into a formal interagency group that is controlled by a local board, with local accountability of staff. The role of provincial departments would then be to provide funding, standards, and consolidation. This would provide for better use of current resources, more synergy, and quicker adjustment to local priorities. (Not all thought this would be feasible or necessarily more effective or efficient. Felt mechanisms are in place to meet local needs and priorities. Others thought that there would still be the same problems attracting and retaining staff.)
- Decentralize so service providers can better meet local needs.

Appendix E

Perceptions and Comments of Users of Mental Health Services

NOTE: the process of client selection was delegated to agencies in each community visited. Clients were not screened to ensure a representative sample was selected. The interviews were not intended to evaluate specific services in selected communities but rather to gain insight to service delivery issues from the perspective of users in the system, and to balance the feedback received from service providers.

Table 1 Client Interviews

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
1. Physician; Mental Health.	Mother. Parent/child and marital problems.	Referred to Mental Health by family physician. Received marriage counselling - group, in Grande Prairie; was put on waiting list.	Mental Health very impersonal and unfeeling, marriage counsellor good though - good experience with group therapy. Problem in having to travel - take time off work and kids out of school every couple weeks.	Good, we're doing better.	If professional counsellor was in community, more people would use it. Teens also need counselling - my son would like to see a counsellor on his own.
2. Mental Health.	Female, anxiety/depression problem.	Friend recommended seeing Mental Health worker. Set up appointment easily, but has to travel to neighboring community every two weeks to see therapist.	Therapy is appropriate but appointments are often broken (believed due to over-bookings, and inadequate booking system/procedures); causes considerable loss of time due to travel. Client has given up and terminated therapy.	OK for a while, but a waste of time now. Don't know what to do; feels need for therapy but will have to travel to city and pay for private psychologist to get it; too costly and time-consuming.	Need Mental Health worker in community.
3. Employment program.	Female. Married. Fairly new in town. Children grown up. Started getting bored/depressed. Decided to look for work.	Called Alberta Career Development & Employment. Referred to local employment program. No problems finding where to go or getting in.	Very helpful, personal, upbeat. Kept in touch.	Very effective. Found a position right away. Hasn't heard other complaints.	Change agency name to make easier for people to locate.
4. Addiction services.	Male. Long history of alcohol abuse and being abusive to family.	Didn't want to continue to be a problem to family. Sought counselling at native addictions program. No access problems.	Good service. Caring counsellors.	Good so far.	Should be an AA group in town.
5. Child Welfare; Mental Health.	Broken family. Child having emotional and behavioral problems. Parent unable to cope.	School didn't have counsellor trained to deal with problem. Tried Mental Health - said workload too heavy. Received psychological services through Social Services.	Met with psychologist every three weeks for three months.	Counsellor terminated sessions, saying problem was worked out - parent and teacher did not agree. Child still has behavioral problem.	Need assessment and case planning services involving parent, child, school and counsellor.
6. Private counselling service.	Female. Daughter and granddaughter both raped and required psychological treatment.	Knew local professional services not available. Went to Planned Parenthood (Edmonton). Referred to private psychologist (for daughter). Knew of specialist in Grande Prairie (for granddaughter).	Appropriate. Travel problems: too inconvenient to go as frequently or as long as necessary.	Effective but not entirely sufficient.	Put psychological counselling under AHCIP so don't have to risk custody to get Social Services assistance.

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
7. Mental Health.	Mother of 15-year-old pregnant daughter with emotional/immaturity problems.	Referred to Mental Health office (located in neighboring community) by Community Health Nurse. Initially, psychologist came to community once every week or two, which was very convenient. Now client has to go to neighboring community to see psychologist once every two weeks, as psychologist no longer visits community.	When psychologist visited community, service was rushed but not bad, good relationship with service provider. Since having to travel to neighboring community for appointments, service has broken down considerably (different therapist). Booking mess-ups often occur, causing client and daughter to miss afternoon of work and school for nothing. Very disgusted. Therapy sessions also very rushed now and of little help - 'How are you doing? OK. Next.' Planning to drop out but feels therapy is still needed.	Very little help overall.	Need therapists in community. Client would be happy seeing Community Health Nurse for counselling but not available.
8. Women's Shelter; Social Services; Subsidized Housing; Literacy Training.	Female. Long-term resident. Mennonite background. Victim of family violence.	Had no knowledge of services available. Remembered an FCSS pamphlet. Enquired. Referred to shelter, then on to other services as situation evolved . No problem finding or getting into services.	Satisfactory.	Good.	Many (e.g., Mennonite communities) just accept their lot. Get people to question their lives first. Then they will start looking for services.
9. Physicians; Mental Health.	Female. Long-term resident. Son hyperactive. Causing family/marital stress.	Saw various doctors. Took son for psychological assessment. Then to Edmonton neurologist. Calgary doctor recommended hospital investigation/treatment - no beds. Saw allergist. Saw nutritionist. Referred to holistic practitioner in Edmonton - special diet.	Dissatisfied with medical community (attitude and skill/knowledge re children's behavioral disorders). Told nothing was wrong. Constantly referred to parenting courses, family counselling, etc.	Nothing worked until special diet. Behavior problems went away.	More training for doctors on causes of behavioral disorders. More specialists for these problems. More control and empowerment for people in dealing with medical profession.
10. Mental Health; school counselling.	Parent dealing with child's grief over father's death, and child's subsequent behavioral problems.	Went to doctor. Referred to Mental Health. Got in quickly, but only for assessment. Talked to school counsellor. School brought in psychologist. Referred on to a youth development program. Three years between initial assessment and treatment.	Psychological services only diagnosed problem but didn't treat it. Less than competent referral and follow-up.	Unknown. Hopeful.	Better supervision of workers to ensure appropriate referral and follow-up. Need to educate consumers about what a good service is.

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
11. Social Services; school counselling.	Female. Long-time resident. Daughter victim of sexual abuse.	Didn't know where to go. Called Health Unit. Referred to Social Services. Social worker did assessment. Referred to community agency in Peace River. No problems getting in. Turnover in agency counsellor. Approached school counsellor and got in right away.	Uncomfortable with style of new agency counsellor. Liked school counsellor better. Daughter opened up.	Didn't help right away, but getting better now. No one seems to specialize in this area.	Need specialists, or backup from specialists for local counsellors who have achieved rapport with client.
12. Mental Health.	Female. Long-term resident. Stress over child's discipline problem.	Not sure where to go. Talked to FCSS. Referred to Mental Health. Got in fairly quickly.	Style appropriate.	Pretty effective at the time to get over crisis.	More parenting programs, parent support groups and preventive family counselling available locally. Better information and referral to help people locate the right service. Reorient hospitals to play stronger role in community health (mental and physical).
13. Mental Health.	Female. Married. Relatively long-term resident. Long history of depression. Decided to seek professional help.	Looked in telephone book. Called Mental Health and got in right away.	Good chemistry. Felt in professional hands. Didn't feel like a "number". Mutual decision to terminate.	Excellent. Probably could have been helped by a trained paraprofessional or minister, but didn't know any.	Maybe counsellors could do "house calls". More publicity to raise awareness that services are available and lower barriers to use. More self-help courses (on videotape or ACCESS network) or more self-help groups.
14. Social Services.	Parents of emotionally disturbed daughter. When child was young, therapist and counsellors (including psychiatrists) did not think her problem was very serious, though parents disagreed. Attempted suicide twice.	Sought services when daughter was in Grade 3, but received no help; continued to act out periodically (socially and through self-mutilation). Social Services finally authorized psychiatric services after daughter attempted suicide. After a few other outbreaks of problem, daughter referred to an adolescent residential treatment program in the city; Social Services wanted to put child under guardianship, as they suspected sexual abuse (very traumatic to family); hired lawyer to protest and won.	Very disgusted with the way Social Services handled case and with the psychiatrists they saw. Social Services caused more problems than they helped with by assuming sexual abuse; mother had to take child to city doctor behind husband's back to verify that the child was not abused; very disturbing. Current psychiatrist in charge of adolescent residential program has little time for parents; simply saying child is doing OK; but won't say what his treatment plans are. Parents feel they have had to continually battle system to get treatment for daughter, and that treatment has not been very helpful.	Poor outlook; parents feel they have lost their daughter, who may never get out of hospital; feel she could have been helped if her problem was properly treated earlier.	Need homemaker for other children when parents have to go to city (weekly) to visit daughter. FCSS has provided good service and advice. Need child/adolescent treatment programs in northern communities, not just in the city. 'Why should we always have to fight the system to get proper service?'

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
15. Special education; sheltered employment.	Male. Long-term resident. Son a slow learner having trouble in school and subsequently in finding employment.	No local special education program. School board placed son four times (different communities) for elementary schooling. No local employment program for mentally disabled. Had to lobby to get a local sheltered employment program started.	Satisfactory.	Good. Son getting experience and self-confidence.	More funding. Big waiting list now for similar clients.
16. Women's shelter; Mental Health; Psychiatrist.	Female. Long-term resident. Marriage breakdown after moving. Long-term history of depression.	Stayed in shelter with counselling. Referred to Mental Health - counselling. Referred to psychiatrist in Grande Prairie - medication. Recent hospitalization and adjustment of medications. No trouble accessing services.	Most services very good. Hospital staff (psych ward) pushy. Not sensitive to different types of depression and most appropriate therapy.	Medication has been effective.	Better training for hospital staff re chemical versus situational disorders, and more relevant therapies. More direct promotion of symptoms so people can recognize their sickness (self diagnosis). More promotion to reduce stigma. More outpatient group therapy. Access by general community to company-sponsored services.
17. Mental Health; Social Services; school counselling.	Parents. Long-time residents. Child having behavior problems at school.	Approached school for help. Referred to Mental Health. Several weeks to get in for an assessment. Went to Social Services. Social worker did assessment. Referred to counsellor in Grande Prairie. Counsellor left. Referred to school counsellor. Investigating possible medical condition.	Things going in slow motion. No one knows what to do. Counsellors don't listen to the parents' description of events and symptoms.	Lack of follow-up from social worker. Counselling not frequent enough and too "fluffy". Ineffective. Child getting worse.	Need competent specialists with school system to deal with behavioral problems at an early stage.
18. Private counselling agencies; Social Services; special education.	Parent. Having behavior problems with son at school. Causing stress in the family.	Talked to school. Referred to local counselling agency. Called RCMP. Talked to Social Services. Referred to counselling agency in High Prairie. Talked to school board. Enrolled son in special school in Edmonton. Not hard to get in to any of the services.	First agency approach too soft. No real counselling. Others OK.	Effective. Steady improvement with each service.	Train teachers to recognize when children are having mental problems. More emphasis on early intervention and treatment. More public education to reduce stigma. Services should be covered by AHCIP so people don't have to beg for help.

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
19. Mental Health; psychiatrist.	Female. Long-term resident. Long history of episodic depression.	Saw doctor - antidepressants. Next episode doctor referred her to hospital in neighboring community- two weeks with some counselling. Last episode hospitalized for one month. Saw psychiatrist and psychologist - medication and counselling. No real delays.	Attitude of counsellors good, but continuity problems and too many cancelled appointments. General practitioners lack knowledge - too much emphasis on medications. Psychiatrist cold, uncaring.	Early treatments were hit-or-miss. Latest treatment effective. Finally got down to the cause of the problems.	Better training for general practitioners regarding mental disorders and use of medications. More emphasis on counselling.
20. Social Services.	Mother of four children. All four children in need of counselling services for behavioral and school problems.	Friend suggested going to Social Services. They arranged and paid for individual and family counselling in Grande Prairie - nothing available in local community to deal with problem.	All right, but travel inconvenient.	Minimal so far but hopeful.	Social Services is very booked and bogged down. Should have people in the community who can deal with these problems.
21. Private psychiatrist.	Female with fatal brain tumor.	Local doctors could not diagnose problem; thought problem was emotional and was put on anti-depressants which made problem worse. Fought to get AHIP to pay for assessment at a major medical clinic in States after several unsuccessful referrals to Edmonton specialists; brain tumor diagnosed. Sought out psychiatrist in community for follow-up.	Referrals made to Edmonton doctors by local physician; Edmonton doctors simply passed patient around, running up a bill of over $60,000 without properly diagnosing problem. Local psychiatrist very good; receiving good service now but is worried what will happen when psychiatrist leaves.	As good as can be expected; medications are reducing symptoms a lot.	Need better access to first-rate physicians.
22. Social Services; subsidized housing.	Female. Relatively new resident. Married with child. Victim of family violence.	Had a relative working at FCSS. Knew services were available. Went to Social Services. Later referred to housing program. Not hard to find or get in.	Satisfactory.	Good.	Hard for single parents to integrate. Need more singles activities. Need someone to help get a singles support group going.
23. FCSS; Mental Health; psychiatrist; women's shelter; family counselling.	Female. Married. Long-term resident. Long-term psychiatric history. Hospitalized once before moving here. In crisis soon after arriving.	Didn't know where to go. Called distress line. Referred to FCSS. Got in right away — counselling and a self-help group. Referred to Mental Health. Hospitalized. Family crisis. Stayed in women's shelter. Referred to community agency — family counselling. Referred back to FCSS. Generally hard to get into services.	Service depends on the individual. Not always the choice available. Too much emphasis on individual counselling.	Turnover in staff compromises quality and consistency of service. Lack of coordination between agencies dealing with the family.	Need more money for staff to reduce turnover; more family counselling services; specialized psychiatric services for teens; more self-help groups with professional backup. Recruit past victims and train as counsellors.

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
24. Social Services.	Parent. Long-time resident. Child having behavior problems at school.	No school counselling available. Knew a friend who had worked for Social Services. Referred to a community agency in Grande Prairie. Got in quickly. Requested family counselling through Social Services. Put on waiting list.	Style seemed good.	Not effective in getting child to open up. Schools don't get family involved early enough. Too little too late.	Need school counsellors in junior high. Problems starting earlier. Schools not on top of bad crowds who are negative influence on children.
25. Mental Health.	Male. Long-term resident. Stress over breakup of marriage.	Called FCSS. Referred to Mental Health in neighboring community. Got in quickly.	Appropriate service.	Very effective in getting over the crisis.	Would be nice to have local follow-up (one-on-one) by Mental Health or a trained paraprofessional.
26. Mental Health.	Female. Single parent. Previous relationship physically abusive. Relatively new resident. Suffered acute stress shortly after moving.	Saw poster at work. Not eligible for company services as a contractor. Referred to Mental Health. Got in right away. Placed in group therapy.	Appropriate. Needed an evening service.	Very effective. Run by a psychologist. Wouldn't trust a volunteer or paraprofessional.	Better publicity of community self-help resources (e.g., courses, books, films). More public education to reduce stigma and to help people recognize the early symptoms.
27. School liaison program; FCSS; Social Services.	Parents of daughter with emotional problems - 'anxiety seizures', suicide attempts. Child placed in foster home as parents couldn't cope; now living on street in Toronto. Parents have been trying to get proper treatment for child for last four years; problem is cyclical but no one seemed to think it was serious.	School liaison worker referred child to FCSS counsellor for problems at school; referred to local psychiatrist who did not think problem was serious. Social Services set up appointments with psychologist who visits community weekly; received three months therapy; some improvement but then deteriorated again. Hospitalized after suicide attempts; placed in foster home twice; back home for a while; now living on streets in Ontario.	No one seemed to delve into problem very deeply; only looked at superficial problems and dismissed them. Social Services wouldn't take child at parents' request; only got involved when child attempted suicide - foster home parent recommended child get professional help but Social Services did not agree; service from visiting psychiatrist was poor; didn't know what parents wanted when they made an appointment to see him; didn't know much about the case, though he was treating her in hospital. Social Services 'just wanted to get child off their case load.' Did not want to work with the child and the family.	Poor; child has run away and is living on the streets in Ontario; is accessing Social Services there for financial support.	Parents do not think the child ever got proper help; when finally got to see professionals, they did not seem to get involved, or take case seriously. FCSS has been good source of advice. 'I would never recommend other parents go to Social Services - too government; not concerned with child only with cost of services; paper pushing takes priority.'

Table 1 – Client Interviews (Continued)

Service Usage	Background	Service Access	Appraisal of Service	Outcome	Client's Comments
28. Probation Officer; FCSS; Private psychiatrist.	Male perpetrator of family violence.	Ordered by court to take course for male batterers in Edmonton; follow-up with local FCSS worker; wife seeing private psychiatrist in Edmonton.	Poor support from probation officer; didn't encourage positive steps. Male batterer's course in Edmonton was very good; local FCSS support very good also, but not able to provide professional counselling. Wife referred to psychiatrist in city; getting appropriate service.	Good; family is getting along much better and father is active in getting local self-help group going for male batterers through FCSS.	There is a definite need for men's group therapy in community. Would like to help set up a self-help group for men but need professional support, but none available in community. Should be better "meshing" of local agencies (Social Services; teachers; hospitals; doctors; etc.).
29. Social Services; Mental Health; private psychologist.	Female, sexually abused as youth, grew up in foster home. Moved to community four years ago and had coping problems; felt isolated and alone.	Got push from family physician to see Social Services and Mental Health but service was not helpful. Started seeing private psychologist one year ago.	Social Services said they couldn't help and Mental Health worker did not understand the problem. Private psychologist good but very costly; don't know if further therapy can be afforded; doesn't know what to do; feels she will 'go to pieces' without therapy.	Uncertain but not promising.	Services must be made more available to the public. Need insured psychological services. Group therapy would be very beneficial. Professionals in community are very overworked, and appointments must be cancelled when emergencies arise (occurs often). 'We pay a lot to live here.'
30. School counselling; Youth Assessment Centre; probation.	Parent. Long-time resident. Child (male) with long-term behavioral problems evolving to depression, suicidal tendencies and violence.	Child in school counselling early on. Child wouldn't cooperate. Parent couldn't get child committed for psychiatric assessment. Long delays in getting counselling directed by courts.	No real counselling received. Police and medical community unfamiliar with procedures for apprehending mentally ill. Court system couldn't seem to impose/ implement services needed.	Totally ineffective.	Better counselling services in the school system to address problems at an early stage. Better access by young offenders to counselling services within the legal system.
31. Mental Health; psychiatrist.	Female. New resident. Previous history of depression. Stress over move and medical problems with newborn child.	Health nurse noticed her condition. Referred her to Mental Health in neighboring community. Took three or four weeks to get in. Turnover of counsellor. Referred to psychiatrist in neighboring community. Three months to get appointment.	One hour counselling every two weeks not sufficient. Wanted more intensive counselling. Psychiatrist very aggressive, not sympathetic. Too quick to prescribe medication.	Not entirely effective. Found own resources and things settled down.	Need day care/baby sitting and more things for moms to do. Need local counselling service, not necessarily a psychologist. More publicity of services available to new residents. Better use of local hospital for other community services.
32. Mental Health.	Parent/daughter problems.	Knew a friend who referred them to Mental Health. No trouble getting in.	Style OK.	Not effective. Child didn't open up. Still needs help. Counsellor hasn't kept in touch.	None.

Appendix F
Survey of Northern Alberta Service Providers: Questionnaire

Survey of Northern Alberta Service Providers

Due Date: Friday, April 6, 1990

The survey is divided into the following two parts:

Part 1: Service Delivery Issues

Part 2: Employment Issues

Part 1 focuses on service delivery issues that are specific to the community, or one of the communities, in which you provide services. If you provide services to more than one community, please select only one of the communities when completing this part of the survey. If workers in your office provide services to more than one community, please decide amongst yourselves which communities each of you will address. Each of you should address a different community.

Part 2 focuses on employment issues that are not necessarily specific to a given community. Please answer the questions as completely as you can. **Your answers to these questions will be kept strictly confidential.** The information you provide will be grouped with that from other service providers in northern Alberta and will not be identified with you personally, nor with any particular community.

To insure confidentiality, **mail both parts of your completed questionnaire directly to the Alberta Management Group (11763-35A Avenue, Edmonton, Alberta, T6J 0B4) in the envelope provided.**

It is very important that we obtain information from a broad range of service providers working in a wide variety of northern settings so that the strategies developed will accurately reflect community conditions and the views of service providers in all of northern Alberta.

Please take the time to complete this survey now.

Due to time constraints, your completed questionnaire must be returned to our office **no later than Friday, April 6th, 1990,** in order to be included in our analysis.

If you have questions about the survey please contact either Ted Weiden (434-4985) or John Chase (464-2278). General questions about the project may also be directed to Brian Pountney (624-6274), Northern Development, Peace River, Alberta.

Thank you for your participation in this important project.

Survey of Northern Alberta Service Providers

Due Date: Friday, April 6, 1990

Part 1: Service Delivery Issues

1) What is the *name* of the community that the following information pertains to?
Name of the Community:

2) Is the community within approximately one (1) hour's drive by vehicle one way to Grande Prairie, Ft. McMurray, Peace River, or St. Paul? (Circle number 1, 2, or 3.)
1. Yes 2. No 3. It is one of these communities

3) for the services listed below that are *not* available either in your community or within approximately one hour's drive one way, indicate *no access*. For all of the others, indicate if they:

(A) deal only with severe cases requiring immediate attention;

(B) are very busy, but have some time for prevention/ promotion work;

(C) have appropriate work loads that allow time for preventive, promotional and other community organization and development work.

If the service *is* available, but only to some residents (for examples, where counselling is available in some schools but not others, or where service is available to Child Welfare cases only), indicate *restricted access* (by circling 5) *in addition* to either A (2), B (3), or C (4).

(Circle the appropriate number or numbers to the right of each service.)

	No Access	(A) Severe Cases Only	(B) Very Busy, But	(C) Work Load Allows Time	Restricted Access	Don't Know
1. School counselling	1	2	3	4	5	6
2. School liaison program	1	2	3	4	5	6
3. Parenting/discipline program	1	2	3	4	5	6
4. Pastoral counselling	1	2	3	4	5	6
5. Child mental health assessment services	1	2	3	4	5	6
6. Youth/adult mental health assessment services	1	2	3	4	5	6
7. Substance abuse treatment	1	2	3	4	5	6
8. Substance abuse self-help groups (e.g. AA, Al-anon, etc.)	1	2	3	4	5	6
9. Individual counselling for mental health problems	1	2	3	4	5	6
10. Family counselling for mental health problems	1	2	3	4	5	6
11. Group counselling for mental health problems	1	2	3	4	5	6
12. Counselling for juvenile offenders	1	2	3	4	5	6
13. Crisis intervention	1	2	3	4	5	6
14. Post-crisis follow-up services	1	2	3	4	5	6
15. Women's shelter	1	2	3	4	5	6
16. Post-shelter follow-up services	1	2	3	4	5	6
17. Psychiatrist and other medical back-up services	1	2	3	4	5	6
18. Other	1	2	3	4	5	6
19. Other	1	2	3	4	5	6

4) First indicate how much *demand* is placed on mental health services in your community by each of the problems listed. Second, indicate the extent to which services in the community have the capacity to effectively deal with each of these problems. (Circle one of the numbers in the *demand* columns and another in the *capacity* columns.)

	Very Low Demand					Very High Demand		Very Inadequate Capacity					Adequate Capacity	
1. Substance abuse among youth	1	2	3	4	5	6	7	1	2	3	4	5	6	7
2. Substance abuse among adults	1	2	3	4	5	6	7	1	2	3	4	5	6	7
3. Behavioral problems among school-aged children	1	2	3	4	5	6	7	1	2	3	4	5	6	7
4. Child abuse	1	2	3	4	5	6	7	1	2	3	4	5	6	7
5. Cognitive dysfunctions in the elderly	1	2	3	4	5	6	7	1	2	3	4	5	6	7
6. Depression/anxiety	1	2	3	4	5	6	7	1	2	3	4	5	6	7
7. Sexual abuse	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8. Battering	1	2	3	4	5	6	7	1	2	3	4	5	6	7
9. Mental handicaps	1	2	3	4	5	6	7	1	2	3	4	5	6	7
10. Major emotional problems	1	2	3	4	5	6	7	1	2	3	4	5	6	7
11. Marital discord	1	2	3	4	5	6	7	1	2	3	4	5	6	7
12. Parenting/discipline	1	2	3	4	5	6	7	1	2	3	4	5	6	7
13. Sexual dysfunction	1	2	3	4	5	6	7	1	2	3	4	5	6	7
14. Suicidal behavior	1	2	3	4	5	6	7	1	2	3	4	5	6	7

5) Is there another mental health issue that is substantially affecting service delivery problems in your community?

1. Yes 2. No

If Yes: please explain: _____

_____

_____

6) How *important* would the following *changes to service delivery* be in *reducing* the problems you identified in questions 4 and 5?

	Not Important					Very Important	
1. Greater availability of professional service providers	1	2	3	4	5	6	7
2. More community-based non-professional care givers	1	2	3	4	5	6	7
3. Better support of existing non-professional care givers by professionals	1	2	3	4	5	6	7
4. Better information sharing among service providers	1	2	3	4	5	6	7
5. Greater use of a team-treatment approach to complex cases	1	2	3	4	5	6	7
6. A single entry system that would facilitate access to mental health services	1	2	3	4	5	6	7
7. Other, specify: _____							
_____							

7) How *important* are the following in relation to mental health problems in your community?

	Not Important					Very Important	
1. Breakdown in traditional ways of living	1	2	3	4	5	6	7
2. Changing community values	1	2	3	4	5	6	7
3. Conditions of employment (shift work, etc.)	1	2	3	4	5	6	7
4. Reduced employment opportunities	1	2	3	4	5	6	7
5. Transiency of the population	1	2	3	4	5	6	7
6. Isolation	1	2	3	4	5	6	7
7. Other, specify: _____							
_____							

8) List *two* conditions or attributes of your community that are important *barriers* to providing good mental health services.

1. _____

2. _____

9) List *two strengths* or *resources* in your community that could be used to help overcome or compensate for the barriers listed in question 8.

1. _____

2. _____

Part 2: Employment Issues

Please Note: Your answers to the following questions will be kept strictly confidential. The information you provide will be grouped with that from other service providers in northern Alberta and will not be identified with you personally, the community you serve, or the community in which your office is located.

10) Who are you employed with?

1. Alberta Mental Health
2. Alberta Family & Social Services
3. AADAC
4. A Municipal FCSS organization
5. A Health Unit
6. School Board
7. An Indian Band or Council
8. Other; please specify: _____

11) Where did you reside just prior to taking your current position?

1. Out of Canada
2. in Canada but not in Alberta
3. Edmonton/Calgary
4. Another urban community in southern Alberta
5. A rural community in southern Alberta
6. This community
7. Another urban community in northern Alberta
8. Another rural community in northern Alberta

12) How long have you provided health/social services to this community? (Specify in years and/or months)

_____Years _____Months

13) Is this your first mental health, social service, or related employment position?

1. Yes 2. No

14) What are the *most* important reasons for taking your current position?

(Circle up to *three* alternatives only.)

1. To get experience
2. I wanted to work in the North
3. for the pay
4. for professional advancement
5. My spouse was transferred here
6. I was transferred here
7. for the job itself
8. Other; please specify: _____

15) Do you feel you were sufficiently trained to work in the North?

1. Yes 2. No: What would have helped?

_____

_____

16) How long do you expect to stay in your current position in the North?

1. I have no plans to leave
2. At least 5 years
3. 2-5 years
4. 1-2 years
5. Less than 1 year

17) If you plan to leave the North *within the next two years*, what are the *most* important reasons for your decision?

(Circle up to *three* alternatives only.)

1. I have no plans to leave the North
2. Professional advancement
3. I want to work/live in a larger community
4. I'm feeling burned out here
5. My spouse is likely to be transferred
6. I'm likely to be transferred
7. Better pay
8. Better working conditions
9. Improved educational opportunities
8. Other; please specify: _____

18) If you plan to leave the North *within the next two years*, which of the following would *most* influence your decision to stay?

(Circle up to *three* alternatives only.)

1. I have no plans to leave the North
2. Nothing
3. Better professional/collegial support
4. Better pay
5. Better opportunities for advancement
6. Reduced work load
7. More time to work with others in the community to address mental health issues

19) How *important* do you think the following would be in *recruiting qualified staff to the North*? Please rank the list from *most* important (1) to *least* important (5).

Ranking

1. Better information about the quality of life available in the North. _____
2. Better pay. _____
3. The inclusion of northern rural practice course work during training. _____
4. Availability of northern practicum opportunities during training. _____
5. More aggressive recruitment practices, e.g., recruiting in other provinces and in other countries. _____

20) Do you have *any* other suggestions for *recruiting staff to work in the North*?

1. Yes 2. No

If Yes: please explain: _____

_____

_____

_____

_____

_____

_____

_____

21) How Important do you think the following would be in *retaining qualified staff in the North*? Please rank the list from *most* important (1) to *least* important (6).

Ranking

1. Better opportunities for educational upgrading. _____
2. Better professional/collegial support. _____
3. Better pay. _____
4. Better opportunities for professional advancement. _____
5. A reduced client load so that workers can develop services and activities tailored to their community. _____
6. Providing professional staff with non-professional sub-ordinates to assist with preventive, health promotion, follow-up, and group work within the community. _____

22) Do you have *any* other suggestions for *retaining qualified staff in the North*?

1. Yes 2. No

If Yes: please explain: _____

_____

_____

If you have further comments about any of the issues in this survey, please include them here or attach a separate sheet of paper, if necessary.

Thank you for participating in this survey.

(Please return this survey to the Alberta Management Group, 11763-35A Avenue, Edmonton, Alberta, T6J 0B4)

Appendix G
Service Access Data

Table A1
Northwest Region
Group A Mental Health Services

City (14 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	100	X			43	0
2. Youth/adult mental health assessment services	100		X		36	0
3. Individual counselling	100	X			21	0
4. Family counselling	100	X			29	0
5. Group counselling	100		X		15	8
6. Counselling for juvenile offenders	82		X		11	21
7. Crisis intervention	100		X		0	0
8. Post-crisis follow-up services	90	X			20	23
9. Psychiatrist and other medical backup	100	X			8	14

Town Service Centre (10 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	89	X			13	10
2. Youth/adult mental health assessment services	100		X		11	10
3. Individual counselling	100		X		0	0
4. Family counselling	100		X		10	0
5. Group counselling	89	X			25	10
6. Counselling for juvenile offenders	71		X		33	22
7. Crisis intervention	100		X		10	0
8. Post-crisis follow-up services	87		X		0	20
9. Psychiatrist and other medical backup	90	X			33	0

15 Other Towns (36 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	90	X			37	3
2. Youth/adult mental health assessment services	84	X			21	6
3. Individual counselling	94	X			9	3
4. Family counselling	86	X			13	0
5. Group counselling	45	X			20	11
6. Counselling for juvenile offenders	71	X			14	19
7. Crisis intervention	84		X		11	9
8. Post-crisis follow-up services	62	X			20	14
9. Psychiatrist and other medical backup	75	X			40	3

13 Small Communities (12 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	50	X			57	0
2. Youth/adult mental health assessment services	55	X			29	0
3. Individual counselling	91		X		27	0
4. Family counselling	60	X			29	10
5. Group counselling	20	X			33	10
6. Counselling for juvenile offenders	40	X			50	0
7. Crisis intervention	73	X			13	9
8. Post-crisis follow-up services	73	X			13	9
9. Psychiatrist and other medical backup	58	X			14	0

* "X" represents median responsiveness score.

Table A2
Northeast Region
Group A Mental Health Services

City (4 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	100		X		50	0
2. Youth/adult mental health assessment services	100	X			100	37
3. Individual counselling	100		X		75	0
4. Family counselling	100		X		75	0
5. Group counselling	100		X		75	0
6. Counselling for juvenile offenders	100		X		25	0
7. Crisis intervention	75		X		0	0
8. Post-crisis follow-up services	100		X		0	25
9. Psychiatrist and other medical backup	100		X		75	0

Town Service Centre (9 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	75		X		29	0
2. Youth/adult mental health assessment services	100		X		22	0
3. Individual counselling	100		X		0	0
4. Family counselling	87	X			25	0
5. Group counselling	80	X			50	29
6. Counselling for juvenile offenders	43	X			0	22
7. Crisis intervention	100			X	11	0
8. Post-crisis follow-up services	71		X		0	22
9. Psychiatrist and other medical backup	78		X		14	0

6 Other Towns (15 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	50	X			50	8
2. Youth/adult mental health assessment services	63		X		33	0
3. Individual counselling	80		X		15	0
4. Family counselling	77		X		23	0
5. Group counselling	50		X		25	13
6. Counselling for juvenile offenders	58		X		38	19
7. Crisis intervention	79	X			25	6
8. Post-crisis follow-up services	75		X		20	19
9. Psychiatrist and other medical backup	71	X			18	6

8 Small Communities (8 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. Child mental health assessment services	71		X		0	0
2. Youth/adult mental health assessment services	71		X		20	0
3. Individual counselling	71		X		20	0
4. Family counselling	57		X		25	0
5. Group counselling	43		X		0	0
6. Counselling for juvenile offenders	50	X			25	0
7. Crisis intervention	100		X		43	0
8. Post-crisis follow-up services	50	X			75	0
9. Psychiatrist and other medical backup	57		X		0	0

* "X" represents median responsiveness score.

Table A3
Northwest Region
Group B Mental Health Services

City (14 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	100		X		43	0
2. School liaison programs	100		X		21	0
3. Parenting/discipline programs	63			X	29	31
4. Pastoral counselling	100		X		0	29
5. Women's shelter	100		X		0	0
6. Post-shelter follow-up services	87		X		0	43
7. Substance abuse self-help groups	100			X	21	0
8. Substance abuse treatment	92			X	8	0

Town Service Centre (10 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	100		X		56	14
2. School liaison programs	100		X		44	13
3. Parenting/discipline programs	71	X			43	13
4. Pastoral counselling	100		X		0	30
5. Women's shelter	22	X			67	0
6. Post-shelter follow-up services	50		X		40	11
7. Substance abuse self-help groups	73			X	13	11
8. Substance abuse treatment	100			X	20	0

15 Other Towns (36 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	97		X		29	3
2. School liaison programs	77		X		31	9
3. Parenting/discipline programs	57		X		42	15
4. Pastoral counselling	100		X		15	25
5. Women's shelter	76		X		20	0
6. Post-shelter follow-up services	48		X		24	15
7. Substance abuse self-help groups	97		X		13	11
8. Substance abuse treatment	77		X		4	0

13 Small Communities (12 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	87	X			64	0
2. School liaison programs	90		X		30	10
3. Parenting/discipline programs	70	X			13	10
4. Pastoral counselling	86			X	25	33
5. Women's shelter	50		X		17	0
6. Post-shelter follow-up services	60	X			17	18
7. Substance abuse self-help groups	67			X	13	0
8. Substance abuse treatment	60		X		29	0

* "X" represents median responsiveness score.

Table A4
Northeast Region
Group B Mental Health Services

City (4 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	100			X	33	25
2. School liaison programs	100		X		75	0
3. Parenting/discipline programs	100			X	25	0
4. Pastoral counselling	67		X		0	25
5. Women's shelter	100			X	25	0
6. Post-shelter follow-up services	100	X			33	33
7. Substance abuse self-help groups	100			X	0	0
8. Substance abuse treatment	100			X	25	0

Town Service Centre (9 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	100		X		44	0
2. School liaison programs	80			X	20	38
3. Parenting/discipline programs	60			X	50	17
4. Pastoral counselling	75		X		25	50
5. Women's shelter	89		X		0	0
6. Post-shelter follow-up services	60	X			0	44
7. Substance abuse self-help groups	100			X	11	0
8. Substance abuse treatment	78			X	0	0

6 Other Towns (15 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	100		X		29	14
2. School liaison programs	92		X		23	13
3. Parenting/discipline programs	86		X		25	12
4. Pastoral counselling	100		X		0	12
5. Women's shelter	62			X	10	0
6. Post-shelter follow-up services	46		X		14	13
7. Substance abuse self-help groups	100			X	7	6
8. Substance abuse treatment	93		X		7	6

8 Small Communities (8 Respondents)	% Reporting Access	Service Responsiveness* Severe Cases Only (1)	Very Busy But (2)	Work Load Allows Time (3)	% Restricted Access	% Don't Know
1. School counselling	60			X	33	33
2. School liaison programs	50			X	67	17
3. Parenting/discipline programs	29		X		50	0
4. Pastoral counselling	50	X			50	33
5. Women's shelter	29			X	0	0
6. Post-shelter follow-up services	33			X	67	0
7. Substance abuse self-help groups	80		X		25	33
8. Substance abuse treatment	29		X		0	0

* "X" represents median responsiveness score.

Appendix H
List of Unsolicited Written Submissions

List of Unsolicited Written Submissions

1. Statement on Community Mental Health Needs. Fort Vermilion School Division #52. February 1, 1990.
2. Tri-Town Ministerial Association. February 6, 1990.
3. Mental Health in Northern Alberta: Addressing the Issues. Grand Centre. February 15, 1990 — A Psychiatrist's Perspective.
4. Alberta Association of Social Workers. February 24, 1990.
5. To Whom it May Concern: Grand Centre, Alberta. February, 1990.
6. Lac La Biche General & Auxiliary Hospital & Nursing Home District No. 78. March 2, 1990.
7. The Psychological Association of Alberta. March 21, 1990.

Appendix I
List of Suggested Solutions

List of Suggested Solutions

Funding

- Compensate northern agencies for training/ travel overhead and cost-of-living in provincial funding formulae.
- Recognize interagency coordination time in funding for positions.
- Initiate grassroots client advocacy groups to lobby for funding.
- Initiate social action by workers to lobby for funding.

Recruitment

- Increase salaries/incentives (fee differential for northern practice).
- Allocate vacant payroll to recruitment costs and incentives.
- Establish an accredited university clinical psychology training program.
- Establish a Provincial Mental Health Institute.
- Implement mandatory rural/northern content in professional training curricula.
- Increase northern practicum placements.
- Establish northern locum pools.
- Promote/advertise the north to students and professionals.
- Cover psychological/social work services under AHCIP.
- Recruit outside of Canada.
- Allow local input into northern job specifications.
- Reduce qualifications necessary for mental health positions.
- Cultivate local paraprofessionals and informal/ natural care givers.
- Promote volunteerism (recruit community newcomers to human services).
- Recruit victims.
- Provide local training of northern resources via university extension.
- Provide bursaries with returning service commitments for training northern resources.
- Promote cost sharing of positions between agencies.

Retention

- Increase rural/northern content in training curricula.
- Inform candidates of job/community environment before hiring.
- Orient new workers to job and community.
- Provide cross-cultural training to northern workers.
- Improve community integration of newcomers.
- Provide consultation/inservice through distance education technology.
- Accelerate pay grids for northern workers (long-service incentives).
- Allocate vacant payroll to inservice.
- Increase training opportunities.
- Improve peer networking opportunities.
- Avoid single person offices.
- Increase job sharing.
- Implement support groups for workers.
- Increase autonomy/flexibility in worker roles.
- Impose minimum 3-5 year employment commitment.

Coordination/Collaboration

- Recognize interagency coordination time in funding for positions.
- Enhance coordination between formal/informal resources.
- Enhance coordination between local/external resources.
- Implement single entry/coordinated case management.
- Increase regionalization of services.
- Increase joint agency programs/pooling of resources.
- Establish umbrella community-based board (advocacy/advisory role to agencies).
- Pool funding to agencies under control of community/regional board.

Roles/Relationships

Community Role

- Focus on community-based vs. institutional services.
- Catalyze community development.
- Foster native community independence.
- Increase community involvement in problem definition, strategy development, methods, standards.
- Increase community involvement in priorities/ funding allocations.
- Increase local input into northern job specifications.
- Establish umbrella community-based board (advocacy/advisory role to agencies).
- Pool agency funding under control of community/regional board.
- Establish local consumer advocacy boards to inform regional authorities.

Worker Roles

- Establish primacy of informal helping systems/ resources/networks.
- Increase role of professionals as consultants and educators to community resources.
- Increase professional support for local groups.
- Implement mental health consultation model (expand network of practitioners).
- Cultivate/train/use local paraprofessionals and informal/natural care givers.
- Integrate local providers on treatment team.
- Increase worker autonomy/flexibility to respond to local situation.
- Increase worker responsibility/accountability to community/client.

Institutional Roles

- Establish hospital as physical/mental health centre.
- Establish travelling/mobile mental health clinics.
- Integrate health and social services.
- Increase access to schools by other services.
- Deliver mental health services through Home Care.
- Increase privatization of service delivery.
- Provide family counselling through FCSS.
- Provide community access to company EAPs.

Client Services

- Establish separate children's mental health service.
- Establish separate native mental health service.
- Define basic mental health services guaranteed to all (fully insured).
- Develop a comprehensive Mental Health Act.
- Publicize services/resources available.
- Educate consumers regarding symptoms.
- Promote new image for mental health to reduce stigma.
- Establish home visits.
- Increase mental health training for medical personnel.
- Improve supervision of client referral/follow-up.
- Increase mental health training for teachers.
- Increase training opportunities for non-professional resources.

Appendix J
Community-Based Services

Community-Based Services

Some important characteristics of community-based services are outlined in this appendix. Much of the material is taken from *Community-based Health and Social Services: Conference Report* published by the Canadian Council on Social Development, 1986. Other material comes from the workshops and community visits of this project.

"In part, the idea of community-based services developed as a response to the need to find a middle ground between individual responsibility and societal well-being. Excessive reliance on the former had led to a chaotic health and social services system, while zealous pursuit of the latter produced the institutional straightjacket of the welfare state. Although institutions clearly serve certain purposes, they are expensive and unnecessarily complex ways of handling many kinds of needs" (p. 15).

Themes of community-based health and social services:

- *Empowerment.* Members of the community must gain information and acquire skills in order to responsibly discharge the decentralized decision-making authority that is theirs as stakeholders in democratized community-based mental health service provision.
- *Participation.* Members of the community must participate in designing, planning, running, and evaluating community-based services. This helps ensure that the services respond to real needs in ways that are socially and culturally relevant.
- *Multi-dimensional approaches.* Since mental health problems are not the result of a single cause, there is no single best approach to dealing with their prevention or cure.
- *Promotion and prevention.* Community-based services conceive mental health as an integral part of the person's whole life — social, economic, cultural, and spiritual.
- *Interdependency with other services.* Agency and institutional changes that promote, not just allow, the development of community-based services will, other things being equal, improve services. However, "if not supported by practical plans and sufficient resources for implementation [programs like deinstitutionalization] can have disastrous and tragic consequences."

Community-based services are not:

- *Standardized.* By their very nature, community-based services are different in different communities because they reflect the distinctness of those communities.
- *Deficit reducing.* Community-based services offer ways of spending health and social services dollars more effectively; they are not a means of reducing governments' overall commitment of resources. "To adopt the policy [of community-based services] without assuring the means for its operation is to pass responsibility while keeping the buck" (p. 7).
- *An individualization of problems.* Community-based services are not a way of shifting responsibility for mental health problems from the public sector to individual sufferers or their families. "Volunteerism and self-help are among the characteristics of community-based services, but this in no way relieves governments of responsibility for ensuring . . . access to adequate and appropriate [mental health] services" (p. 7).
- *A panacea.* Community-based services are not the solution to mental health services delivery problems. They can be an important part of solutions that include continuing commitment of resources to more traditional services when and where appropriate.

Community-based services can:

- restore a measure of public participation in decisions, foster community cohesiveness, and promote a sense of continuity
- enhance choice and a sense of individual responsibility as well as personalizing the collective responsibility felt by community members
- offer flexibility to make services more culturally, socially, politically and economically relevant to local needs and changing priorities
- increase cost-effectiveness by appropriate de-professionalization through the use of local care givers and better coordination of services
- increase integration among a wide range of

services so that clients are viewed as people, not symptoms

- make services available in more locations and for more of the time
- emphasize prevention and promotion, thereby leading to mental health, not just the treatment of mental illness.

Some of the characteristics of community-based services are:

- *Autonomy and decentralization.* "Decisions about the design, management and delivery of services are made locally, often by the people receiving them" (p. 21).
- *Innovative.* A community-based service responds to its particular community in ways that may be novel both in terms of services and administration. If the resources (finances and expertise) are available for appropriate documentation, this innovation can lead to new knowledge that can then be used by others.
- *No single model.* Because the conditions that affect mental health are many, the approaches to promoting mental health and treating mental illness must also be many.
- *Non-bureaucratic and de-professionalized.* Service recipients and other community members participate actively in designing the content and delivery of services. Thus, professionals are not empowered to design services to meet their own needs. Furthermore, the roles of service providers are not rigidly pre-defined and will evolve as local service providers become more skilled and as the community changes.
- *Client population.* Service providers have an intimate knowledge of the client population because they are part of it. This promotes the social and cultural relevance of the services.
- *Sponsoring group.* All community-based services begin with some sponsoring group indigenous to the community. The first task of the community development process that we are recommending is the identification or gathering of such a group from within the community. The first task of that group will then be to acquire an appropriate mandate from the community-at-large.
- *Holistic approach.* Services are provided within the familial, cultural, spiritual, occupational, and economic context of the clients. Problems are not treated in isolation.
- *Wellness approach.* Services generally emphasize the creation of mental health, with the treatment of mental illness as an important but not primary consumer of resources. A gram (ounce) of prevention is thought to produce more well-being in most instances than a kilogram (pound) of cure. Emphasis is usually on primary prevention, with fewer resources devoted to secondary prevention, and the fewest resources going to tertiary prevention (treatment). However, this pattern should vary to reflect the needs of the community.
- *Services are not static.* Communities change continually and so must the health and social services, including mental health services, that they receive if those services are to remain appropriate to the needs of the community.

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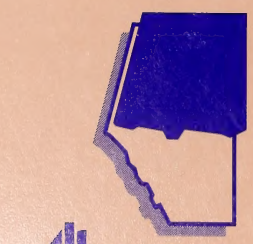

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